Maryland Department of Health & Mental Hygiene AIDS Administration

Ryan White Part B Statewide Coordinated Statement of Need

January 5, 2009

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I. Introduction

The Maryland AIDS Administration, established in 1987 as a division of the Maryland Department of Health and Mental Hygiene, leads public health initiatives regarding HIV (Human Immunodeficiency Virus), the virus that causes AIDS.

The vision of the AIDS Administration is a Maryland with no new HIV infections. The AIDS Administration is dedicated to working with public and private partners to reduce the transmission of HIV and help Marylanders living with HIV/AIDS live longer and healthier lives. Most HIV services are delivered through third parties, including local health departments, other governmental organizations, community or hospital-based health care facilities and community-based organizations throughout the state. The AIDS Administration directly administers the Maryland AIDS Drug Assistance Program (MADAP). In addition, the AIDS Administration conducts program evaluation, health services research, and analysis and surveillance of the epidemic.

The mission of the AIDS Administration specifically mentions the importance of input from affected communities in the development, implementation and evaluation of the system of care for people infected and affected by HIV in Maryland.

II. Legislative Requirements and Purposes of the SCSN

The Ryan White Care HIV Treatment Modernization Act of 2006 requires that Ryan White grantees develop a Statewide Coordinated Statement of Need (SCSN). According to the federal Health Resources and Services Administration (HRSA), the SCSN is a mechanism for addressing key HIV/AIDS care issues and enhancing coordination across Ryan White programs and Parts. This document is intended to serve as a framework for programmatic action that will strengthen Maryland's HIV care service delivery system over a three-year planning cycle. The Maryland AIDS Administration, as the HRSA-funded Part B program for the state, is responsible for coordinating the SCSN for the state of Maryland. The purpose of this document is to provide an update of progress since the last SCSN and to identify the emerging trends in HIV/AIDS health and support services, critical gaps in services in Maryland and the issues which cut across all Parts of the Ryan White program in Maryland. The SCSN is intended as a broad statement of need upon which future plans and funding applications can be based.

III. Description of the 2009 SCSN Process

Regional Breakdowns

The AIDS Administration organizes the state into five regions (Central, Eastern, Southern, Suburban and Western) for HIV/AIDS planning purposes. The regions are composed of the following jurisdictions:

Central: Anne Arundel, Baltimore, Carroll, Harford, and Howard counties; and Baltimore City

Eastern: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties
Southern: Calvert, Charles, and St. Mary's counties
Suburban (to Washington DC): Montgomery and Prince George's counties
Western: Allegany, Frederic, Garrett, and Washington counties**.**

Jurisdictions in Maryland are part of two Eligible Metropolitan Areas (EMAs) and one Transitional Geographic Area (TGA) that receive Ryan White Part A funds. The Washington, DC EMA includes five Maryland counties (Frederick, Montgomery, Prince Georges, Charles and Calvert). The Baltimore-Towson EMA is comprised of Baltimore City and the six surrounding counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's. Cecil County is part of the Wilmington, Delaware TGA. The remainder of the state is primarily rural.

Steps of the SCSN Process
The following multi-step process was used to complete the SCSN.

Step One: Collect needs assessment documents and review information that identifies service needs and barriers to care on a regional and state level.
In the late summer of 2008, Maryland AIDS Administration staff began a comprehensive review of needs assessment documents from various sources throughout the state in an effort to amass information delineating needs and barriers in specific regions or special populations. Documents varied in content, format, and timeframe, ranging from statewide needs assessment to regional public input summaries to agency survey results. Also included were articles published in medical journals, research and evaluation summaries, surveillance study analyses, focus group reports, and consumer knowledge survey results. A complete list of the documents included in the review can be found in Appendix B. Identified needs, including prevention and policy issues are summarized in this document

Step Two: Conduct regional community dialogues
Five regional community dialogues were held in the fall of 2008. Efforts were made to include a wide range of participants for the open forums, successfully drawing a total of 145 clients, community members and providers. Representatives from Part A-, B-, C-, and D-funded programs participated. These forums served as a venue to hear consumers' voices. Consumers were given the opportunity to share concerns, suggestions and experiences according to service categories. PLWHA's comprised approximately 27% of the community dialogue attendees.

Step Three: Summarize and compare HIV/AIDS epidemiological data.
The Maryland AIDS Administrations Center for Surveillance and Epidemiology produced graphic and tabular data on reported HIV and AIDS cases and persons living with HIV and AIDS, which are presented in Section III of this document (see Appendix C for the complete Maryland HIV/AIDS Epidemiological Profile). These data highlight variables such as race/ethnicity, gender, age, and mode of HIV transmission, and trend information on cases and deaths. This information is presented on a statewide and regional basis.

Step Four: Summarize environmental considerations and emerging trends, special populations, and service needs and barriers.
Environmental considerations and emerging trends that impact the HIV/AIDS epidemic are described in Section V. The issues outlined in this section are crosscutting statewide trends that need to be taken into consideration for future planning. All needs assessment documents, Regional Advisory Committee minutes, and priority setting results were collected and synthesized, culminating in a comprehensive list of service needs and barriers that will be given high priority in future planning. Discussions regarding special populations that are disproportionately affected by the HIV/AIDS epidemic are found in Section VI of the document. Section VII outlines the service needs and barriers identified.

Step Five: Prepare, finalize, and distribute the SCSN document.
Using the synthesis of information gathered above, the SCSN was written and used as a guide to create priority goals for the three-year Part B HIV Services Comprehensive Plan.

IV. HIV/AIDS Epidemiology

How Data is Collected and Reported

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV and AIDS reporting, instituted reporting for HIV-exposed newborns, changed Maryland's HIV reporting from a code-based to a name-based system as is done with AIDS cases, increased the restrictions on the use of surveillance data, and increased the penalties for misuse of surveillance data. The state is in the midst of a major effort to transition from code-based to name-based HIV surveillance; hence, the data collected under the new system were not yet available for this report.

This report uses the HIV and AIDS surveillance data available in 2008 that was used during the statewide planning process and for the FY2009 Ryan White funding application. Under this system, AIDS cases and symptomatic HIV cases were reported to the health department using the patient's name by physicians. HIV positive test results and CD4+ T-lymphocyte cell counts less than 200 cells per microliter were reported to the health department using a patient unique identifier number by all laboratories licensed by the State of Maryland. HIV data are available only for those tested since 1994, when HIV surveillance began. HIV and AIDS incident cases are not necessarily mutually exclusive since HIV cases may have progressed to AIDS during the presented time period and therefore count as both a new case of HIV and a new case of AIDS. HIV and AIDS prevalent cases are mutually exclusive categories; therefore, HIV prevalent cases are only those cases that have not developed AIDS. Due to the delay in case reporting, the data are presented with a one year lag, at which point it is estimated that over 90% of cases will have been reported.

Source of AIDS Incidence and Prevalence Data

The Maryland AIDS Administration maintains a confidential registry, by name, of all AIDS cases that ever lived or received care within the state. Physicians are responsible for primary case reporting. Secondary case reporting is performed by the state and local health departments

through review of death records, hospital discharge summaries, tuberculosis and cancer registries, Medicaid claims files, ADAP records, and laboratory reporting of low CD4 cell counts. Determination of Maryland residence at the time of initial AIDS diagnosis is done in conjunction with the individual states and the Centers for Disease Control and Prevention (CDC). State and national death databases are routinely searched to determine the vital status of all cases. The incident AIDS cases in Table 1 represent the number of new Maryland AIDS cases diagnosed during the two-year period from January 1, 2006 through December 31, 2007 as reported through June 30, 2008. The HIV and AIDS prevalence described in Table 1 are the number of Maryland resident cases alive on June 30, 2007, as reported through June 30, 2008.

Source of HIV Prevalence Data

Prior to April 24, 2007, laboratories certified and licensed by the State of Maryland are required by law to report to the state and local health departments evidence of HIV infection and CD4+ T-lymphocyte counts less than 200 cells per microliter for all Maryland residents using a unique patient identification number (UI). The UI is a fourteen-digit number consisting of the last four digits of the Social Security number, the date of birth (mm,dd,yyyy), and codes for race/ethnicity and gender. Sensitivity analyses performed by applying the non-named UI number to the name-based AIDS case registry have confirmed that the UI number, when complete, is highly unique (99.987% unique in over 15,000 AIDS cases). The Maryland AIDS Administration maintains a registry, by UI number, of all HIV positive non-AIDS cases that live in Maryland and have received a positive HIV test in the state since June 1, 1994. As of December 31, 2008, all HIV cases have been transitioned from a code to name based reporting system.

Notes on Data Collection and Interpretation

The HIV prevalence estimates for race/ethnicity, gender, age, and mode of exposure include HIV cases diagnosed since June 1, 1994 that have not died or progressed to AIDS as reported through June 30, 2007, as reported through June 30, 2008. These figures are likely to be an undercount of prevalent HIV infections for three reasons. First, tests performed on Maryland residents at facilities outside of Maryland are not reported. Second, individuals that tested positive prior to 1994 and have not been re-tested will not be included until they are either re-tested or develop AIDS. Third, the CDC estimates that, as many as 21% of HIV infected individuals do not know their HIV status. Information on HIV mode of exposure is collected through follow-up investigations of incident HIV cases. Systematic collection of this information began in the spring of 1998 and is currently available on approximately 54% of recent HIV cases.

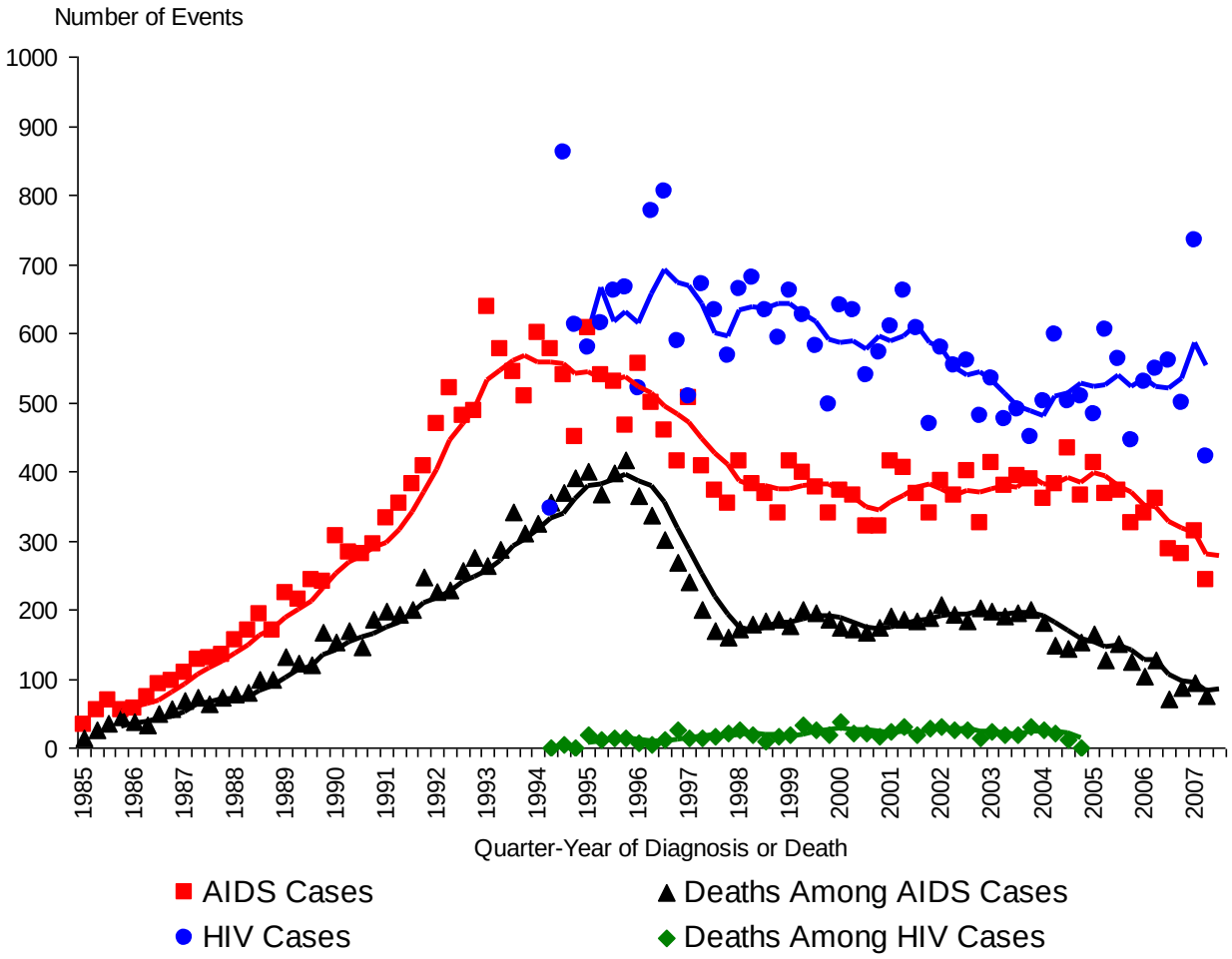
Maryland's HIV/AIDS Epidemic Compared to the National Epidemic

Approximately 5.3 million people reside in Maryland which ranks 19th among all states relative to population size; however the state was 9th in cumulative number of AIDS cases (30,571 through 2006). Maryland had the third highest AIDS case report rate (29.0 cases per 100,000 population) among states and territories and the Baltimore-Towson metropolitan area had the second highest AIDS case report case rate among major metropolitan areas (37.7 cases per 100,000 persons) in 2006. This is in comparison to the national AIDS case rate of 12.9 cases per 100,000 persons. Maryland's case rate is 2.24 times higher than the national rate. The EMA's, AIDS case rate is 2.9 times higher than the national rate. Nationally, the proportion of AIDS cases that are women is 26%; in Maryland it is 34%.

The number of incident (new) AIDS cases diagnosed in each quarter increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a substantial decline in both the number of new cases of AIDS (to 243 in the second quarter of 2007) and in deaths among AIDS cases (to 76 in the second quarter of 2007). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in an increase in the number of people living with AIDS each year (prevalence). The number of new HIV cases reported each quarter has declined slightly since surveillance began in 1994 (2% per year to 554 in the second quarter of 2007). However, the total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. The number of deaths among HIV cases has remained low and stable since 1994, with a more pronounced decrease in AIDS and HIV deaths since 2004.

HIV/AIDS Data by Region

Figure 1. HIV and AIDS Case Trends: Incident (Newly Diagnosed) HIV and AIDS Cases and Deaths among HIV and AIDS Cases by Quarter-Year through Second Quarter 2007 as Reported through 6/30/08

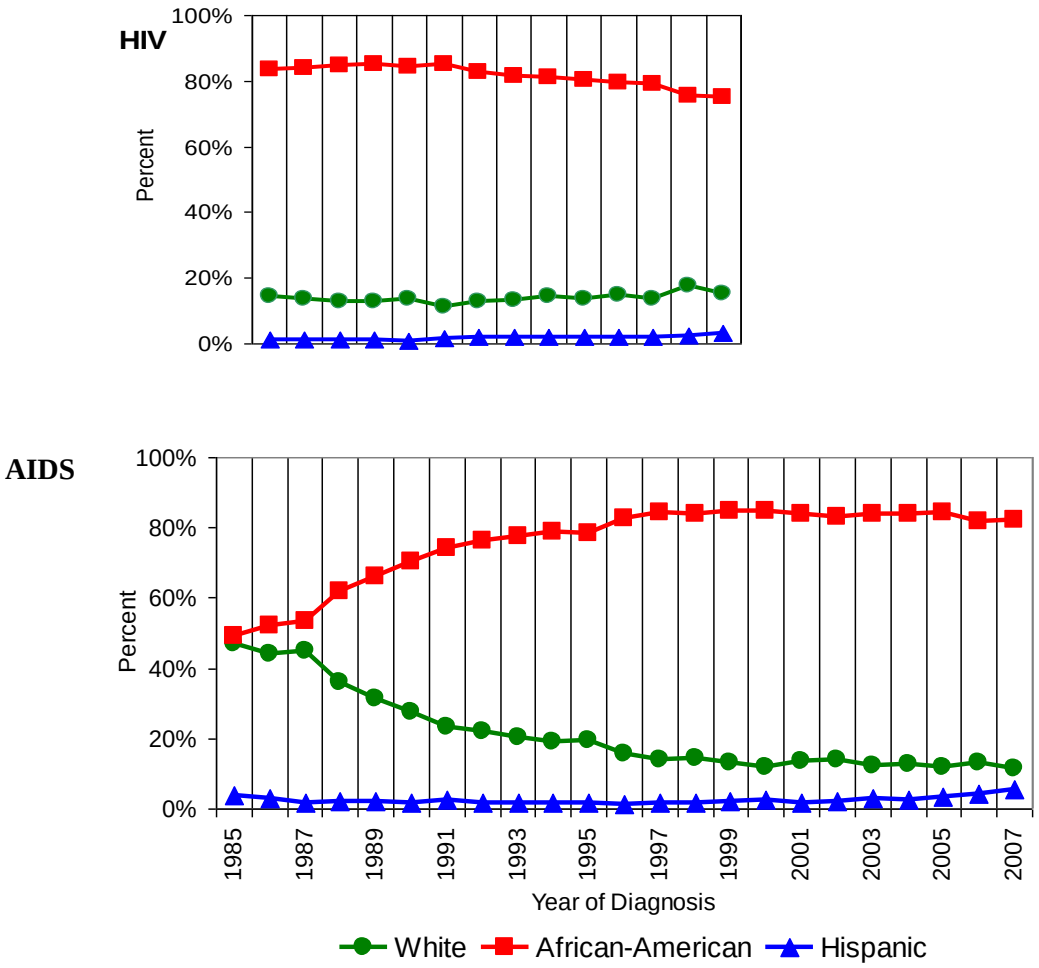


Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.

There were a total of 34,024 living HIV and AIDS cases in the State of Maryland as of June 30, 2007, of which 19,042 (56%) were HIV cases and 14,982 (44%) were AIDS cases. About half (48%) of all reported living HIV and AIDS cases in Maryland were residents of Baltimore City at time of diagnosis. The Central Region, which includes Baltimore City and the surrounding counties, Anne Arundel, Baltimore, Carroll, Harford, and Howard, reported a total of 62% of all living cases. The two counties adjacent to Washington, D.C., Montgomery and Prince George's counties (with 9% and 16% of cases, respectively) make up the Suburban Region with 24% of living cases. A large percentage of HIV and AIDS cases are diagnosed within the state correctional system (8% of living HIV/AIDS cases). The Eastern Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties) reported 3% of all living cases. The Western Region (Allegany, Frederick, Garrett, and Washington counties) reported 2% of all living HIV and AIDS cases, and the Southern Region (Calvert, Charles, and Saint Mary's counties) reported 1% of all living HIV and AIDS cases.

Maryland living HIV and AIDS cases are predominantly African-American (81%), male (64%), and middle-aged (60% of cases are 30-49 years old). The largest single demographic group is African-American males, aged 40-49, with 21% of all HIV and AIDS cases. The percentage of female cases has been increasing over time. Of all AIDS cases diagnosed in 1985, 10% were female. This proportion has steadily increased to 39% of AIDS cases in 2007. Thirty-eight percent of all HIV cases in 2007 were female. The percentage of African-American cases has been increasing over time. Of all AIDS cases diagnosed in 1985, 49% were African-American. This proportion has steadily increased to 82% in 2007. Seventy-five percent of all HIV cases in 2007 were African-American.

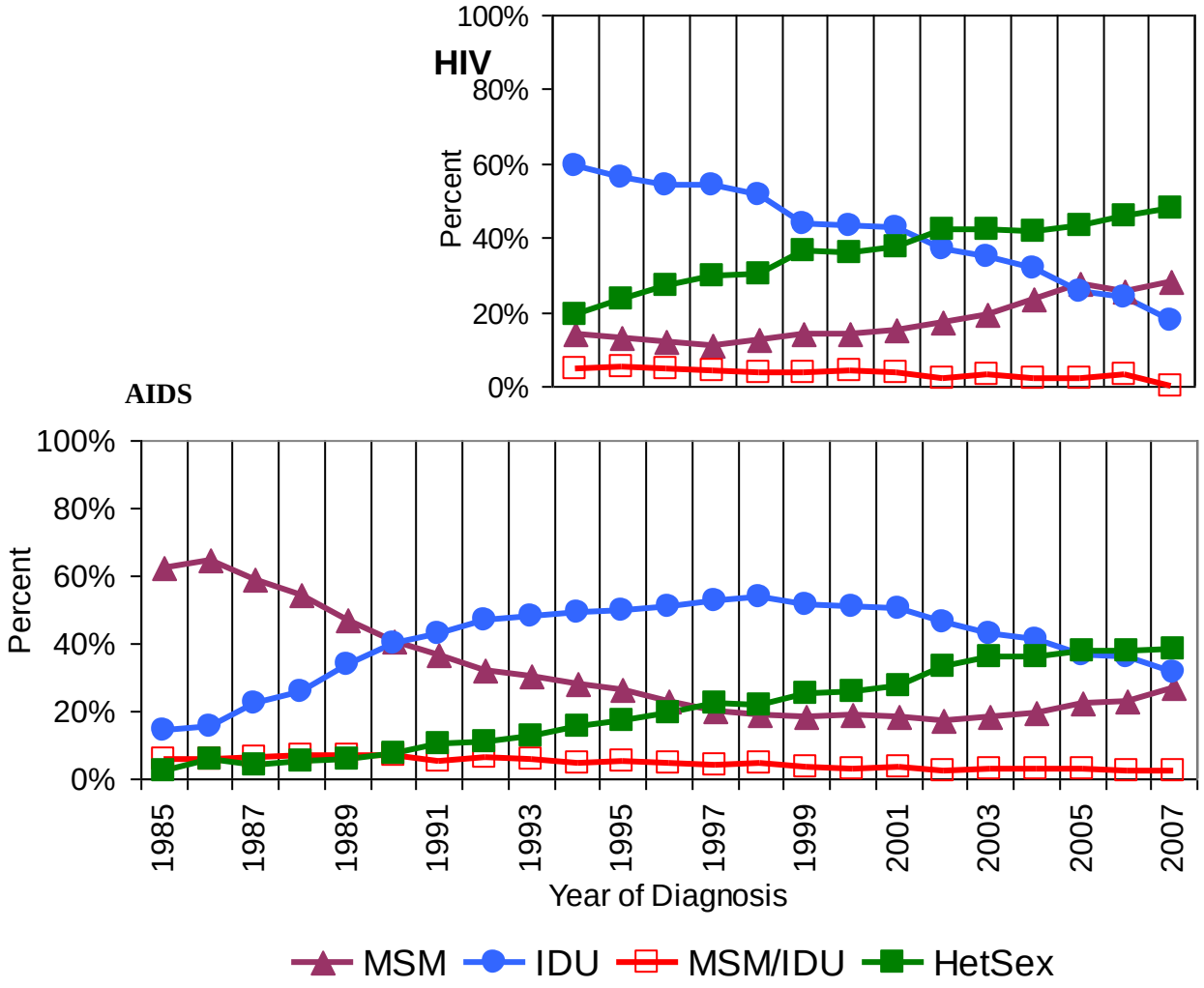
Figure 2. HIV and AIDS Case Race/Ethnicity Trends: Proportions by Race/Ethnicity of Incident (Newly Diagnosed) Cases during each Calendar Year Reported through 6/30/08



Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.

Men who have sex with men (MSM) was the most common HIV transmission risk group for AIDS cases until 1990. In 1991, injection drug use (IDU) became the most commonly reported exposure among newly diagnosed AIDS cases. Heterosexual contact (HetSex) has represented an increasing proportion of reported exposure among all new AIDS cases, surpassing MSM in 1997 and IDU in 2006. Injection drug use was the predominant mode of HIV transmission for HIV cases. However, by 2002 a greater proportion of newly reported HIV cases have identified transmission risk as heterosexual contact, and since 2005, there have been more MSM cases than IDU cases.

Figure 3. HIV and AIDS Case Exposure Category Trends: Proportions by Exposure Category of Incident (Newly Diagnosed) Cases during each Calendar Year Reported through 6/30/08



Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.

Presented in Table 1 below are Maryland's reported two-year AIDS incidence (January 1, 2006 through December 31, 2007), AIDS prevalence on June 30, 2007, and HIV non-AIDS prevalence on June 30, 2007 using data reported through June 30, 2008. The HIV/AIDS data generated by the State of Maryland are used rather than that provided by the CDC because 1) the State's data are used in all phases of assessing need, planning for services, and allocating resources, 2) the State's AIDS data are more current than the CDC data, and 3) the State's HIV data represent actual case counts whereas the CDC HIV data are based on statistical estimates using data from other states. June 30th is used for the prevalence data because this is the end of the code-based HIV reporting period and the name-based HIV data is not yet available.

Table 1: AIDS Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category

	AIDS Incidence 1/1/06-12/31/07		AIDS Prevalence 6/30/07		HIV (non-AIDS) Prevalence 6/30/07	
	N	**%**	**N**	**%**	**N**	**%**
Total	2,262	100.0	14,981	100.0	19,042	100.0
Age*	**N**	**%**	**N**	**%**	**N**	**%**
<13	1	0.0	38	0.3	171	0.9
13-19	40	1.8	145	1.0	157	0.8
20-44	1,329	58.8	6,733	44.9	9,929	52.1
45+	892	39.4	8,065	53.8	8,785	46.1
Race/Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**
White, non-Hispanic	282	12.5	2,356	15.7	2,173	14.0
Black, non-Hispanic	1,856	82.1	12,084	80.7	12,604	81.4
Hispanic	108	4.8	463	3.1	278	1.8
Asian/Pacific Islander	15	0.7	65	0.4	53	0.3
American Indian	1	0.0	13	0.1	32	0.2
Multi-race/Other	0	0.0	0	0.0	339	2.2
Not Specified**	0	---	0	---	3,563	---
Gender	**N**	**%**	**N**	**%**	**N**	**%**
Male	1,407	62.2	9,936	66.3	11,873	62.5
Female	855	37.8	5,045	33.7	7,109	37.5
Not Specified**	0	---	0	---	60	---
Exposure Category	**N**	**%**	**N**	**%**	**N**	**%**
MSM/IDU	36	2.4	486	3.7	123	1.8
MSM	365	24.6	3,224	24.3	1,045	15.3
IDU	506	34.1	5,441	41.0	2,365	34.7
Heterosexual	560	37.8	3,832	28.9	3,022	44.3
Pediatric	10	0.7	197	1.5	231	3.4
Other	5	0.3	76	0.6	37	0.5
Not Specified**	780	---	1,725	---	12,219	---

* Incidence, age at diagnosis. Prevalence, age on 6/30/2007.

** Not Specified was not used in calculating percent distributions.

Source: Maryland Department of Health and Mental Hygiene, AIDS Administration, Center for Surveillance and Epidemiology, December 24, 2008.

Epidemiological Trends

The number of new AIDS cases diagnosed each year has remained stable at around 1,550 per year since 1998. However, the number of living AIDS cases has been increasing by about 800 cases per year during this same time, an average 10% per year increase in AIDS prevalence. HIV prevalence has also been increasing since 1998, by almost 1,100 cases per year, an average increase of 12% per year. The demographics of prevalent HIV and AIDS cases have not changed substantially in the past two years. However, consistent with longer-term trends, the distribution of cases by exposure category has been slowly changing with fewer injection drug user cases and more heterosexual contact and MSM cases. At the end of 2000, the HIV/AIDS prevalent cases were 19% MSM, 48% IDU, and 26% heterosexuals, while by the middle of 2007 they were 21% MSM, 39% IDU, and 34% heterosexuals.

V. Environmental Considerations and Emerging Trends

Emerging trends are defined as "evolving circumstances, thought, policies, procedures, or resources which affect service delivery." Participants statewide identified various emerging trends and environmental considerations that have had an impact on the service system. Since there is considerable overlap between emerging trends and environmental considerations, they have been combined in this report.

Legislative Changes

There have been several significant statutory changes in the field of HIV/AIDS since 2005. The primary change at the federal level was the passage of the Ryan White HIV Treatment Modernization Act of 2006. In Maryland, the passage of the Maryland HIV/AIDS Reporting Act in 2007 and legislation entitled "HIV Testing- Informed Consent and Treatment" in 2008 have changed the legal landscape significantly.

Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA). The RWTMA of 2006 was signed into law on December 19, 2006. The provision with the most significant impact on Maryland included modifications to the federal funding calculations for HIV care services. RWTMA changed the basis of funding from the number of estimated living AIDS cases in a jurisdiction to the names-based reporting of actual living HIV/AIDS cases in the jurisdiction. Although Maryland had been collecting AIDS case information by name since the 1980's, the state began its HIV surveillance using a coded identifier in 1994 to assuage concerns about stigma and information privacy. Maryland's system was inconsistent with RWTMA's new requirements. Maryland changed its HIV reporting system in 2007, which is discussed below.

While RWTMA changed the funding allocation formula for states and territories, RWTMA included provisions that provided an opportunity for states that were not using named-based HIV surveillance systems to transition to such systems without significant disruptions to funding. For federal fiscal years 2007-2009, states that did not have a sufficiently accurate and reliable names-based HIV reporting system in place by December 3, 2005 were eligible to continue receiving federal funds under a waiver system as long as they: 1) instituted all statutory and regulatory changes necessary to provide for a names-based HIV reporting system by April 1, 2008, and 2) submitted a plan to the federal government to make the transition to a names-based HIV reporting system by October 1, 2006. Maryland complied with both requirements. It is important to note that RWTMA's hold harmless provision applies to 95% of the funding formula and can continue through federal fiscal year 2010.

RWTMA also mandated that any unobligated funds be redistributed through their respective supplemental funding streams. Any unobligated carryover must be expended within the next fiscal year.

Maryland HIV/AIDS Reporting Act. In response to the new requirements to qualify for federal funding under RWTMA, Maryland enacted the Maryland HIV/AIDS Reporting Act. Of primary importance, the act changes the state's HIV surveillance system from a code-based HIV reporting system to a name-based system. The act also requires physicians who care for patients who are HIV positive or AIDS-defined to report surveillance information to Maryland's Secretary of Health and Mental Hygiene and to local health officers. Additionally, the act

requires laboratories to report information on positive HIV test results to the Secretary. Further, the act requires certain institutions to report information on patients in their care who are HIV positive or AIDS-defined to the Secretary and to local health officers.

HIV Testing- Informed Consent and Treatment Act. In April 2007, the Maryland General Assembly passed legislation (HB781/SB746) that required the AIDS Administration to form a work group to review the CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings", best practices, research and data on HIV counseling and consent processes. The workgroup was comprised of HIV-infected individuals, HIV/AIDS advocacy organizations, HIV service providers and other stakeholders. The process yielded a comprehensive set of recommendations on potential changes to current Maryland law for HIV counseling and testing processes, which was given to the Maryland General Assembly in December 2007. During the 2008 legislative session, the General Assembly passed House Bill 991/Senate Bill 826, entitled "HIV Testing-Informed Consent and Treatment Act", in an effort to increase access to HIV testing by removing reported barriers. This act alters the requirements for informed consent for HIV testing. Under the act, if testing is ordered at a health care facility, informed consent no longer needs to be documented on a separate, written form, but must be documented in the medical record. Testing performed at any other location requires a separate written informed consent form. The act also provides that an individual administering pretest counseling may utilize a wider array of communication methods based on the individuals needs and testing history. Additionally, the act requires that an individual with a positive test result must be referred to treatment and supportive services. Further, the act requires health care providers of prenatal care to notify pregnant patients that they will be tested for HIV as part of routine, prenatal care, unless they decline such testing. Providers of labor and delivery services are required to consider offering rapid HIV testing to women with unknown HIV status, and to offer antiretroviral prophylaxis to those who test positive for HIV.

HIV Testing

CDC estimates that 21% of individuals with HIV do not know their status. Knowing one's HIV status is shown to prevent partner infections by reducing high-risk behaviors. Results of a behavioral surveillance project for men who have sex with men in the Baltimore metropolitan area showed surprisingly high HIV rates among African-Americans in particular, and most of those infected were not in HIV primary medical care. Of those infected, two thirds of the population is unaware of their status. The AIDS Administration has actively working to increase access to HIV testing through the following initiatives:

- Passage of legislation mentioned in the previous section;
- Education and outreach to healthcare providers, community health centers, and hospitals to encourage routine HIV testing;
- Investment in HIV prevention programming in correctional settings, including the launch of rapid testing; and
- Increase in testing in emergency rooms, substance abuse facilities, STD clinics and other settings.

Risk Exposure Category Trend:
As evident in the epidemiological section, risk categories have shifted in Maryland. Heterosexual transmissions are approximately fifty percent and it is difficult to overcome the perception of HIV/IADS as a "homosexual" or "gay men" disease so that heterosexuals seek or receive testing.

Men who have Sex with Men (MSM) transmission has also shifted. In 2006, 24 % of newly diagnosed HIV cases reported MSM as the mode of exposure, surpassing injection drug use as the most common mode of HIV exposure. (2007 AIDS Administration Annual Progress Report to CDC, p. 46) There is a disproportionate impact on MSM of all races/ethnicities. The MSM population has diverse service delivery needs. It is very difficult to reach this population with HIV education and testing for reasons including racism, homophobia, and lack of access to health care.

Development of More Specialized HIV Planning Groups
While the Maryland Community Planning Group (CPG) and the Regional Advisory Committees (RAC) have focused on big picture efforts such as statewide and regional priorities and the overall consonance between resources and needs, more targeted planning groups have emerged to address narrower topics with more detail. Examples of these groups include: Baltimore City Commission on HIV/AIDS, Prince Georges County Syphilis Response Team, MSM Response Team, Transgender Response Team, NASTAD African American Women Forum. These have emerged in addition to the original planning groups such as the Washington DC and Baltimore EMA Part A Planning Councils.

Faith-Based Initiative
In 2005 and 2006, ninety faith leaders from across the state met to work with the AIDS Administration to develop a strategy for the Maryland Statewide HIV/AIDS Faith-Based Community Initiative, which aims to advance HIV awareness among religious leaders and followers. To date, 767 persons have attended 42 workshops, 8 regional conferences have been held, and a variety of technical assistance visits have been conducted.

Late Diagnoses, Late Entry into Care
Since the advancement and availability of HIV drug therapies, getting people into care for continued treatment to suppress viral replication has become a national strategy to decrease HIV transmission. Providers across the state report they are seeing sicker clients coming into clinics for the first time. Residents of the Baltimore EMA were questioned in the 2007 Consumer Survey about the time between diagnosis and seeking care. While nearly 60% reported engaging in care within a month of their HIV diagnosis, over 13 % waited 1-6 months, 7% waited 6-12 months, and 19.7% waited more than one year after diagnosis to engage in care (Baltimore EMA Consumer Survey 2007).

Increasing Client Self-Management
A common theme that emerged in the SCSN process is the need for client self-sufficiency, or, more broadly stated, empowerment, and provider support for this development. This need is particularly acute because individuals living with HIV and AIDS are living longer lives and health care funds are increasingly unable to meet their on-going needs. The concept of client

self-management is being supported by providers to build clients' self-efficacy in managing their own health. To complement client self-management goals, participants from the SCSN meeting stressed the need for providers to have empowerment and skills training necessary to encourage PLWHA to maintain a healthy lifestyle. Prevention among HIV-positive individuals was called for by a high number of participants and mentioned in all regions at the 2008 RAC meetings. Many specifically listed the need for positive self-management training (PSMT) for persons living with HIV/AIDS, need for HIV education/empowerment for PLWHA, need for support group for clients doing own research with guidance from Health Department staff, and need for self-management training for people living with HIVAIDS. Positive self-management and empowerment trainings are needed in order for clients to take greater responsibility for their own health and disease management. The AIDS Administration is currently funding a pilot client self-management training at the Moore Clinic at Johns Hopkins University Hospital.

Complexity of Insurance Programs Facing Case Managers, including Medicare Part D
Case Managers across the state expressed concern during the SCSN process about the increasing challenge of helping clients manage their interaction with the range of insurance programs with which they participate. Case Managers state that they are spending increased amounts of time learning about the insurance companies, what they cover, and advocating for clients regarding problems with coverage. Since Medicare Part D was instituted on January 1, 2006, consumers and case managers have been forced to learn a complex and changing pharmaceutical insurance program that, with concepts such as the "donut hole", created challenges in coordinating benefits. Medicare Part D also provided challenges for the Maryland's ADAP (MADAP). To ensure that the Ryan White funds for MADAP were used as the payer of last resort, MADAP staff needed to ensure that clients had signed up for Medicare D and for all subsidy programs for which they were eligible, and that MADAP was billed appropriately during the "donut hole".

Vendors Receipt of Level Funding.
Providers in the SCSN process voiced the challenge of maintaining their current systems of care when their costs increase each year, but their award from the AIDS Administration for Part B or Part D is level from year to year. Given the increase in staffing costs, providers state they are faced with the challenge of reducing the full-time equivalent (FTE) staffing for the program, or maintaining the FTE and reducing the other program costs in the budget.

Expansion of Client Level Data
Since January 2004, all Part B, Part D and state-funded HIV service providers in Maryland have been required to submit client level data in an electronic, unduplicated format. In order to standardize submission of client level data and improve the data collected, providers are using or upgrading to Ryan White CAREWare, free public-domain software designed for grantees and providers. Ryan White services data is analyzed for service utilization patterns within geographical areas and by demographic trends. It is also used to gauge client utilization of core services and provide a more proficient way of collecting performance measures for program monitoring. The Baltimore and Washington Part A Programs have similar reporting requirements. The impact of HRSA's requirement for providers to submit Client Level Data starting in 2009 is not yet known.

VI. Special Populations

This section addresses the specific needs outlined from needs assessment documents and community dialogue notes for the following populations: immigrants, especially those with limited English proficiency, youth, pediatric cases, recently incarcerated persons, homeless persons, pregnant HIV-positive women, substance abusers, rural communities and sexual minorities. African-Americans in Maryland are disproportionately impacted by HIV. In 2006, 75% of new HIV diagnoses were African American while census data report that only 28% of Maryland residents are African Americans. Because of this disproportionate impact, special attention and emphasis are given to services for African Americans. Meeting the diverse needs of special populations of PLWH/As in Maryland – those that have a disproportionate need for HIV-related services – is a primary goal of the AIDS Administration, in accordance with HRSA's emphasis on eliminating disparities in access and services.

Immigrants, especially those with Limited English Proficiency
Maryland has a growing immigrant population, especially in the counties surrounding Washington, D.C. SCSN participants indicated that the lack of knowledge about insurance and drug assistance programs is a prominent barrier facing immigrants who are living with HIV/AIDS. Additional barriers include stigma, isolation, shame (especially among women) and fear of disclosure of HIV serostatus. SCSN participants also discussed that many immigrants are not aware of services available to them regardless of their immigrant status (legal or illegal). Participants remarked that many providers would not start medications for migrant or transient patients because they anticipate that they will not be able to be treated if and when they move to another location. The impact of stigma can make continuity of care difficult for providers who may not see the patient on a regular basis or know where patients are receiving primary or specialty care.

Case managers are often not familiar with immigration laws and are uncertain how to deliver services to immigrants regardless of their legal/illegal status. SCSN participants indicated that there is a need for provider education about transient high-risk populations so that they may anticipate periods of time when seasonal workers are prevalent in an area and plan outreach strategies in advance. If providers know where client plan to go next, the provider can connect clients with organizations where they can receive care.

Another barrier to receiving care is undocumented immigrants' fear of accessing services provided by the government. Immigrants, therefore, are often wary of the local health departments. SCSN participants felt that this was further complicated in some counties where the health department is the only provider of HIV care. HIV-positive persons who are undocumented immigrants without Social Security numbers may provide barriers to applying for government-sponsored programs. This may intensify concerns about HIV testing and treatment with regards to consent forms, deportation, and immigration status. These barriers to care may be more prevalent in smaller communities, such as with migrant laborers in the Eastern region.

Linguistically and culturally competent services were identified as the top needs for limited English proficiency PLWHA. SCSN participants indicated that it is challenging to find primary care and specialty providers that are bilingual. Additionally, these bi-or-multi lingual providers

are often available on a limited basis, which creates a barrier to quality care. Translators are often not competent in medical terminology, and in general, translators may not be available when they are needed. While only 1.9 % of respondents to the 2007 Baltimore EMA Consumer Survey indicated a need for translation services, 57.1% of these had not received these services within the prior 12 months.

Behaviorally-Infected Youth

Adolescents comprise an increasing percentage of new HIV infections in Maryland. Over 50% of Maryland's youth living with HIV reside in Baltimore City. Many positive youth are hard to reach and difficult to engage or retain in care. An estimated 826 infected youth ages 13-24 lived in the Baltimore-Towson EMA in 2006. The lack of access of many adolescents and young adults to culturally competent medical services and the fact that teenagers who are most likely to become HIV-infected are often those who are the most disenfranchised, contribute to this disturbing trend in the epidemic. Even when adolescents know their status, many do not receive the care they need.

Efforts have been made by service providers to determine appropriate ways to transition youth into adult care and to reach those youth that are not in care. Qualitative information was collected from the Ryan White Part D Youth Initiative Community Advisory Board (CAB) to determine needs for youth program planning, development and funding. For example, surveys and focus groups were conducted to identify primary barriers for youth when accessing and receiving services, identify life skills needs and identify effective approaches when assisting youth transitioning into adult care. These findings assisted program staff and providers to tailor services for transitioning youth into adult care. Quality care and treatment of HIV-positive adolescents is a priority for providers throughout the state.

SCSN participants indicated great need for primary care, mental health care, and HIV prevention education among youth sub-populations such as parenting youth, African American youth, substance abusing and/or homeless youth. There is also a need for expanded services for affected siblings and other family members in order to assist them in helping youth PLWHA. Other gaps in services for youth PLWHA include information on how to navigate the health system, health education, job training, mentoring and peer education. In order to improve the health of HIV-positive youth, SCSN meeting attendees recommend providing incentives to increase the number of youth providers that are both clinically trained and culturally competent. In addition, non-traditional clinic hours may make it easier for youth to access healthcare and case management services and early prevention interventions to help prevent youth avoid high-risk behaviors.

Perinatally-Infected Children

Due to the remarkable advances in preventing and treating HIV/AIDS, there has been a dramatic reduction in mother-to-child (perinatal) transmission over time. This has led to fewer children in Maryland becoming infected with HIV/AIDS perinatally. As of June 30, 2008, there were 16 children 0-12 years of age living with HIV, the majority of whom resided in Baltimore City. Needs specific to pediatric PLWHA include helping families deal with disclosure and helping children decide when it is the best time to disclose their HIV status. Participants expressed a

need for more comprehensive assessments with regard to developmental and mental health needs of the whole family including caregiver support services.

Barriers to addressing these needs include lack of communication between the Department of Social Services, the school system and consumers with regards to the consumer's eligibility for services. SCSN participants noted that many parents perceive that the Department of Social Services and schools are not helpful and are therefore afraid to ask those organizations for assistance. Strategies to bridge these gaps included providing caregiver support, and updated information on clinical issues and services in the community. SCSN participants noted that there are specific pediatric sub-populations especially in need of services, including: pre-adolescents, Latinos, African Americans, Asian Americans and immigrants.

Mechanisms discussed to implement these strategies included creating a database for providers to stay current on what is available for clients. This effort would require the involvement of other service providers (i.e. Social Services, Head Start). On-going HIV education for professionals (school teachers & administrators, nurses, doctors) should be mandated with an emphasis placed on maintaining a dialogue with the educational system. Sensitivity training for providers was also viewed as a priority to bridge service gaps and meet needs. This is especially necessary for emergency room providers and interns who may see clients on a one time or acute basis.

Incarcerated and Formerly Incarcerated

In Maryland, eight percent of HIV/AIDS cases are in correctional settings. Identified needs for HIV/AIDS services and prevention with positives among the incarcerated focuses on three sub-populations: individuals currently incarcerated, those just entering the prison system, and those preparing to leave the prison system. The SCSN participants reported that access to proven prevention methods, including condom distribution during incarceration, is a need. Support systems for PLWHA are needed in incarcerated settings. The SCSN participants also recognized a need for routine testing upon entry and proper medical attention. Improved coordination of transitional services, including primary medical care and medication continuity, is considered a significant need.

SCSN meeting attendees noted that perceptions of weakness and the fear of a breach of confidentiality prevent disclosure of HIV status while incarcerated. Lack of adequately trained staff in the penal institutions creates a setting in which these barriers are strengthened.

Strategies to address these service gaps include the visibility of case managers and representatives from community organizations "at the door of the jails" (pre-release and immediately upon release) to connect individuals with the services they will need. Better coordination between prison medical providers, case managers, and external service providers was also reported as a means to assist the recently incarcerated. Specific steps to implement this may include developing a guide for inmates with information regarding service providers and resources available post-release, along with a solid re-entry plan monitored by a case manager.

Newly released inmates present unique service delivery challenges. All forms of personal identification have to be coordinated upon release, along with filing applications to determine

eligibility for government benefits, including housing. Many persons are discharged with very tentative housing arrangements. Substance abuse and mental health issues complicate matters. This population needs medical case management prior to release and support systems in place during the discharge process. Employment and job readiness services, which are not available under RW, must be located and clients referred. Secondary prevention education is critical for this population. There is a need to train staff to deliver prevention models to help HIV-positive inmates reduce their sexual and drug related risk behaviors after release so they can avoid transmitting HIV to their partners. Service gaps, in addition to the above mentioned housing and substance abuse include counseling to improve health literacy and knowledge of HIV/AIDS services and mental health services.

Homeless Persons

It is estimated that between 3,000 and 4,000 individuals are homeless on any given night in Baltimore City. Studies indicate that among the homeless, co-morbidities are common. The homeless are more likely to be unemployed, to have less access to health care, and, if HIV+, to not be receiving or adhering to HAART. Services to homeless PLWHA must start with meeting basic living needs to stabilize their lives and to stay in care. The co-morbid conditions that often accompany homeless persons complicate and add increased costs in keeping persons in medical care.

Top needs reported for homeless PLWHA included the availability of permanent housing, life and employment skills, and treatment for other issues that may affect them, such as mental illness, substance abuse and lack of transportation. Sub-issues related to available housing include the need for proper storage of medication for HIV/AIDS prescriptions and other medications.

Among the significant barriers for homeless PLWHA is stigma. Landlords may not want to have HIV-positive tenants or tenants that have been homeless. Housing that is available may not meet codes and standards. Also, providers reported that staff working with this population often experience burnout due to limited resources. Staff turnover has a negative impact on the continuity of care provided to homeless individuals.

Strategies to address these gaps include increased staff training, especially training for case managers to properly assess a client's readiness for housing in order to help place them. Additionally, training for case managers and landlords with regard to interaction between homelessness and HIV compared to homelessness and other diseases (e.g., diabetes, etc.). Life-skills training for homeless persons was also identified as a strategy to improve access to services.

SCSN participants proposed that a consistent and meaningful definition of homelessness across all agencies, along with funding sources that focus on the person and not only the finances are necessary to help this population. Participants noted that homeless PLWHA should be represented on planning councils and in community forums to promote awareness of the issues facing this population and to also foster political empowerment among homeless PLWHA. SCSN participants felt that it is necessary to educate the providers, funding sources, government, and community at large of the special needs of the homeless PLWHA population.

Pregnant HIV-Positive Women
In 2005, the Maryland AIDS Administration conducted a survey on how hospitals with obstetric services in Maryland address the issue of HIV testing of pregnant women. In the spring of 2008, the Maryland State Medical Society, MedChi, partnered with the AIDS Administration to conduct a follow up assessment of perinatal HIV screening policies, practices and perinatal HIV prevention needs of Maryland hospitals. Of the 28 labor and delivery hospitals which responded, 13 stated that they have a policy/protocol for providing rapid tests to women in labor and delivery; 15 responded that they do not. Out of these 15, 9 have rapid tests available in labor and delivery and 6 do not have these tests available. The primary barriers given to implementing rapid HIV testing in labor and delivery included the low volume of cases, lack of knowledge of current practices and protocols, cost, and lack of physician education.

SCSN participants identified the top needs for the pregnant HIV-positive women as HIV education, prenatal and HIV care referrals, and access to rapid HIV testing. Education pertaining to perinatal transmission for all providers and clients is needed along with referrals to appropriate care and specialists. There needs to be rapid HIV testing available in hospital labor and delivery units for all women presenting with an unknown HIV status. Hospitals must also have AZT and other drugs available to provide treatment once a woman with HIV disease presents for delivery. The SCSN attendees emphasized a need for HIV testing and care education for all pregnant women; training for obstetricians in HIV care, transmission and testing; enhanced access to substance abuse treatment for pregnant women; expanded efforts to identify HIV-positive pregnant women who are not under the care of a clinician; more pre-conception counseling for HIV positive women; expanded transportation in the counties; more bilingual capacity among obstetrical staff and; improved cultural competency among all staff working with HIV-positive pregnant women.

Substance Abusers
Studies have shown that substance abuse is associated with delays in accessing HIV care, difficulty establishing care, poor adherence to medications and poor adherence to appointments once in care. According to the Alcohol and Drug Abuse Administration's Maryland Epidemiology Profile, the rate of substance abuse in the general Maryland population is 5,947.3 per 100,000. This report estimates that there were 315,000 illicit substance users monthly in Maryland between 2002-2004. In 2003, Baltimore Substance Abuse Systems Inc. (BSAS) estimated that there were up to 59,000 chronic illicit substance users in Baltimore City.

A major challenge in Maryland, as also cited in the earlier SCSN, is the lack of treatment slots. When persons are ready to enter treatment, it is critical that beds are available to them. When HIV positive individuals are also actively using drugs, they may demonstrate limited or poor adherence to medication and treatment regimens. Many HIV providers therefore will not start persons on HAART until they are off drugs. Treating substance abusers who are HIV positive involves more complex service needs and requires greater supportive services. There is generally a high incidence of co-morbidities and this population often needs housing, emergency financial assistance and transportation.

SCSN participants identified top needs for substance abusing PLWHA included: long-term residential treatment facilities, education for providers and communities on substance abuse and other co-morbid conditions, and a statewide resource list to assist in making appropriate referrals. Participants also identified a need for more intensive case management for substance abuse client.

Rural Populations

SCSN participants reported that access to testing and knowledge of resources for HIV medical and support services are the main barriers in rural communities. Participants noted that many rural PLWHA find out their serostatus only when they are being hospitalized for something else, for example, an acute condition.

SCSN attendees reported that in order to break down barriers facing rural communities, there is a need for stronger partnership between private and public health care systems. According to SCSN participants, rural PLWHA need to become more able to self-manage their own care. Participants feel that clients need to move away from depending on case managers and need to learn how to become more self-sufficient. It is especially difficult in rural regions because of stigma. With self-management, the client would need to take initiative to access care.

Participants described that in rural settings there is often a lack of an open PLWHA community. This is a "huge issue" as rural PLWHA feel they cannot disclose their HIV status to their family and friends and do not have any social support or peers. This lack of community and subsequent lack of support networks is also a barrier for youth PLWHA in rural areas.

SCSN participants reported that infectious disease providers who have specific training or experience in HIV are rare in rural areas. Participants believe that there need to be more incentives for specialized providers to serve rural communities. In addition to the lack of infectious disease providers in rural areas, there also needs to be more case management services especially for the Latino population and translator services for Spanish-speaking and deaf clients.

Sexual Minorities

In order to serve the needs of sexual minorities (specifically Gay, Lesbian, Bisexual, Transgender- GLBT), SCSN participants felt that community organizations, especially in rural communities, would benefit from capacity building. In addition, the participants felt that there is a great need for peer educators and support for organizations that train and manage peer educators. SCSN participants noted that greater visibility of peer educators would help people feel more comfortable with living with their disease and their sexual orientation. There is a lack of a support network because many GLBT and PLWHA do not disclose their HIV infection and their sexual orientation for fear of stigma.

Barriers confronting GLBT PLWHA include a lack of targeted resources and a lack of cultural sensitivity. SCSN participants feel that these barriers can be overcome when providers feel comfortable talking about sex and sexual orientation with their clients. According to participants, GLBT clients often mistrust the healthcare system and are therefore hesitant to access care and disclose their HIV status, especially in rural regions. To overcome these barriers, participants report that providers need to help clients feel comfortable discussing

sensitive issues with them. One way this may be accomplished is to tailor medical forms to be more inclusive of gender orientation and same sex partners/spouses' information. Additionally, SCSN participants commented that healthcare providers should be aware of other challenges facing clients that are GLBT. For example, if a client is transgender, it may be more difficult to get housing, which therefore makes it more difficult to manage their health and adhere to treatment.

A group of specific concern within the sexual minority community is African American men who have sex with men (MSM). MSM refers to a diverse population of men, regardless of how they may identify themselves: gay, bisexual, or heterosexual. They also have diverse service delivery needs and are difficult to reach with HIV education and testing, for reasons such as homophobia, racism, and lack of access to health care. They are often distrustful of medical providers and may enter care at a later stage of diagnosis. In the U.S , from 2001-2004, African American MSMs accounted for nearly half (49%) of HIV diagnoses among African American men. A survey conducted by the CDC in 2004-2005 in five U.S. cities, including Baltimore, found that the infection rate among African-American MSMs contacted in the study was more than double that among white MSMs. Of the five cities in which MSMs were tested, HIV incidence was highest in Baltimore (8%). (Engaging PLWH/As in Care, p. 37)

VII. Service Needs and Barriers

This section summarizes documented and perceived needs and barriers. Documented needs and barriers are those supported by specific evidence and/or quantitative information from sources outlined in Appendix B. Perceived needs and barriers are statements made by sources that are not in formal reports, such as notes from the community dialogues. Whether formally or informally documented, all accounts reflect the awareness of consumers and caregivers with direct experience accessing the delivery system, providers and case managers on the forefront of service delivery.

Accessibility and availability of services

Improving access to quality health care is a critical step towards improving health outcomes for PLWHA in Maryland. The availability of services, and access to those available, was a common challenge listed in the SCSN meetings across the state. Clients, especially in the rural regions, highlight the need for trained infectious disease providers to provide their general care in a manner that is appropriate for their HIV/AIDS needs. Moreover, there is an increasing lack of specialty care providers, including care for co-morbidities, OB/GYN, emergency, and pediatric care. As identified in the 2001 and 2006 SCSNs, the need for increased days and hours and expansion of clinic locations and services is a need resulting from the rising number of PLWHA who live longer and are able to return to the workforce. While efforts have been made to increase service hours, days, and locations, access to care continues to be a concern.

Increased testing has led to an increased number of persons seeking services. Along with the increased number of people living with HIV, the work load for service providers has increased, resulting in burn out and provider turnover. New providers need to be given more in-depth HIV training on a routine basis. This training was cited in the earlier SCSN and was highlighted in all

the 2008 RAC meetings. In a parallel manner, many RAC participants, especially in the rural regions, cited the lack of trained providers in their area, particularly primary care doctors and even infectious disease physicians knowledgeable about HIV, available services, and referrals.

Privacy and confidentiality training and sensitivity and cultural competency training have been identified as growing needs, especially in the rural areas of Maryland. As was highlighted in the Special Populations section, the need for linguistic and cultural sensitivity, translators, and competencies was alerted to in both rural and urban regions. Latinos and African immigrant populations were specifically cited as requiring provider sensitivity in care.

Lack of client knowledge of available services

In the 2007 Baltimore EMA Consumer Survey, the most commonly cited barrier to care among EMA-wide consumers was insufficient knowledge of how to access services. "This barrier signifies either (1) communication problems between providers and consumers, either because the provider has not provided sufficient information or because the client has not been clear enough about his or her needs, or (2) client difficulty with correctly assimilating and retaining information about available services. As consumer needs evolve, there must be ongoing dialogue that supports (1) consumer's communicating their evolving needs and (2) providers' sharing information about available services efficiently and effectively.

Stigma and Discrimination

"HIV/AIDS-related stigma has been found to play a significant role in whether infected persons access or maintain primary medical care. One recent study examined the level and impact of HIV-related stigma in a culturally diverse sample of persons attending an urban HIV clinic. Using a combination of quantitative and qualitative methods, the researchers found that 'stigma emerged as an insidious deterrent to integrating HIV primary care (e.g. medications, clinic appointments) into daily life.' (Engaging PLWH/As in Care, p. 56)

Providers and consumers consider stigma and discrimination as on-going crosscutting issues in Maryland. According to the SCSN discussions, needs assessment results, and open forum meetings, consumers and providers stress that HIV stigma is a barrier to obtaining services for HIV care, mental health, oral health, affordable housing, and access to medication. Stigma and discrimination are also consistent concerns of the emerging and known special populations. The specific populations include persons with limited-English proficiency, immigrants, residents in rural areas, GLBT persons, incarcerated persons, homeless persons, substance abusers, and youth. HIV stigma prevents disclosure to family members and obtaining services from healthcare providers.

Dental care

Consistent with the findings from the 2001 and 2006 SCSNs, participants agreed in the 2008 RAC meetings that there was a great need for more extensive oral health services. Dental care is a high priority for many participants. As persons with HIV live longer, it is important that they have access to quality oral health care. Persons with missing teeth, periodontal disease, or soft tissue lesions may not be able to take in necessary nutrition, and can compromise their health. IDU's are particularly vulnerable to oral diseases due to the effects of substance abuse.

609 respondents in the Baltimore EMA Consumer Survey of 2007 responded yes when asked if they felt they needed oral health care. However, almost half (44.2%) of those in need had not received the service in the year before the survey. Of these respondents, 25% stated that they did not know how to acquire oral health care, while another 15 % said they could not afford the co-payment.

Case Management

RAC participants in all regions stressed the on-going problem of unmanageably high case management case loads, "multiple roles" for case managers and a related high turnover of case managers. This was also cited as a serious problem in the 2006 SCSN. Obviously, the high turnover rates create difficulties and time constraints for both the agencies and the clients. For clients, the need to tell their story over and over again to new case managers can act as a barrier to seeking care. The 2007 Baltimore Consumer Survey reported that almost all of the respondents indicated a need for case management, and that **11.7%** stated that they needed case management but were not receiving it.

Many SCSN participants stated that there is inconsistency among case managers. Providers and clients alike are advocating a statewide training certification program, mentorship, networking, sensitivity and cultural competency trainings, and venues for sharing resources, new information, and etc. Others also proposed a centralized case management access system.

Housing Assistance

Stable housing is fundamental to success in the lives of persons with HIV/AIDS. This is particularly true because many struggle with co-morbid conditions that make the tasks of daily living even more challenging. Without a home, stress levels increase, further compromising already fragile immune systems. Individuals are exposed to chaotic housing shelters or the uncertainty of life on the streets. Essential nutritional needs are easily neglected or forgotten. While coordination between health and social services is improving, some PLWHA have reported having to choose between attending medical appointments or standing in line to assure a place in a housing shelter for the night. Complex treatment regimens become more difficult to monitor and are frequently derailed when faced with unstable living situations. Appointments with health care and human service providers are more likely to be missed or not scheduled at all. Outreach workers are less likely to be able to find their clients in order to offer ongoing support and treatment. Ryan White-funded housing providers and HOPWA (Housing Opportunities for Persons with AIDS)-funded providers share two goals: to increase permanent, affordable housing resources for individuals and families with HIV/AIDS, and to promote integration of supportive service options for people with HIV/AIDS.

SCSN participants ranked transitional housing/shelter, long-term rental assistance, and other housing needs, as the three most inaccessible housing-related services. Furthermore, "Housing" was ranked the greatest need, above all other service categories. It is reported that neither HOPWA nor Ryan White funding for housing-related services is sufficient to meet the needs. 303 respondents to the Baltimore EMA Consumer Survey from 2007 expressed a need for housing services. Of these, more that half said they had not received it. Among the respondents who had received temporary housing assistance within the past 12 months, about **17%** received rent money to prevent eviction, and almost **80%** were helped to enter transitional housing. The

most commonly cited barrier to receiving this service was not knowing how to get it, cited by around **40%** of the EMA respondents who needed this services.

There is a lack of affordable decent housing for low-income individuals and families throughout the state of Maryland. In addition, there is a deficiency of housing assistance services. Regardless of HIV status, clients experience long housing wait lists and shortages in beds in existing transitional shelters. The housing laws now require credit checks for placement and landlords often rely upon credit scores to determine placement and eligibility. Furthermore, security deposits have drastically increased beyond that of the target populations' financial capability.

SCSN Participants suggested integrating HIV support and housing services in housing facilities, including: life skills, medication management, budget management and trained staff to administer a behavioral health to address issues of "arrested development" and coping deficits that are common in the targeted populations. There is also a need for accurate assessments of a client's readiness for housing. This strategy would build a more comprehensive approach to existing service delivery systems.

Mental Health

An estimated 26.3 % of the general population in Maryland has a diagnosis of either anxiety disorder or depressive disorder, with the highest prevalence in Baltimore City. SCSN participants felt that all persons with HIV could benefit from some form of mental health services. Furthermore, 58% of participants felt that mental health services were difficult for clients to access. Participants ranked mental health as the sixth greatest need for PLWHA, and one of the three greatest barriers to obtaining services. There are major cultural and stigma-related barriers to using mental health services. One attendee stated: " A solid mental health foundation is necessary for all other services to work: for HIV medication adherence, for substance abstinence, and for service utilization." Those from the rural regions particularly stressed the lack of availability of mental health treatment and counseling services.

Well over half the respondents (about **59%)** of the Baltimore EMA 2007 Consumer Survey felt they needed mental health services, up from **47.5%** in 2004. Over one fifth of these (**23.2%** EMA-wide, **23.5%** in Baltimore City, and **21.5%** in the counties) indicated an unmet demand, an overall increase from 2004 levels, When those expressing unmet demand were asked why they had not received this service, **23%** felt they had not needed it at the time but did need it now, while **12%** said they were either unaware of or did not know how to access mental health services.

There is also a growing need for mental health services for special populations, including the pediatric population and limited-English proficiency consumers. Services also need to be made available for family members of HIV-infected persons. With the increased number of people living with HIV who are in need of mental health services, there is a growing need for increased days, hours, clinic locations and services.

Substance Abuse and Addictions Services
Substance abuse continues to be a major issue for PLWHA in Maryland. The Baltimore EMA Consumer Survey showed that, compared to the 2004 survey results, the proportion of respondents in need of substance abuse treatment in Baltimore City increased significantly, from **34.0%** in 2004 to 42.6% in 2007, as did the city's unmet service demand, which rose from **14.4%** to **21.4%.** As the Baltimore EMA Consumer Survey states, "The sizable increases in demand and, in the city, unmet demand for this service – combined with the fact that IDU is a leading transmission mode in the EMA – suggests that substance abusers must remain a population of particular focus in future planning."

An integrated approach to providing substance abuse and addictions services for people living with HIV/AIDS was re-iterated this year as previously. The increasing numbers of clients with substance abuse problems requires that case managers and other providers be educated about substance abuse, co-morbidity, cultural differences and other issues that may impact treatment outcomes. Providers stressed a need for an extensive list of drug treatment resources to be made available to both providers and clients. As in the earlier SCSN, the need for culturally competence substance abuse services was cited multiple times in the RAC sessions.

The great need for more treatment slots in all modalities in accessible locations, especially inpatient and outpatient clinics outside of Baltimore City, was noted. Participants in the rural regions specified their challenges in the SCSN meeting: in the Eastern region, participants stated that the "trend is an on-going 'no-progress', with an increase in drug use among youth and the older population; in the rural Western region, participants noted increased heroin use in some counties and a lack of treatment facilities. Other counties stated that addiction counselors are not adequately trained in HIV and there is a lack of needle exchange programs.

Prevention and Education
As a result of increased testing, earlier identification of HIV, and the introduction of HAART, many more people are living with HIV and AIDS for longer periods of time. As a result, there is a greater need for prevention education and counseling for HIV-positive persons. In 2003, CDC issued recommendations on Incorporating HIV Prevention into the Medical Care of Persons Living with HIV, which noted that "medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors, communicating prevention messages, discussing sexual and drug-use behavior, positively reinforcing changes to safer behavior, referring patients for services such as substance abuse treatment, facilitating partner notification, counseling and testing, and identifying and treating other sexually transmitted diseases (STDs)." The Maryland AIDS Administration, in accordance with this guidance, has been integrating prevention with primary care.

Maryland's HIV prevention priorities are as follows:
1. Persons living with HIV/AIDS
2. Heterosexual
3. Men who have sex with men
4. Injection drug-users
5. Special populations (Latinos Deaf, Transgenders.)

(All behavioral groups emphasize African Americans due to disproportionate impact.). These priority populations reflect the Centers for Disease Control and Prevention requirements and the risks associated with new HIV infections in the state.

Despite successes in providing education, SCSN participants reported a continued need for basic HIV and AIDS education, as well as updates on new information for both clients and providers. Participants also indicated that there was a continued need to incorporate prevention education into HIV primary care. Participants mentioned several times the lack of knowledge of services and resources which are available; several suggested a need for a jurisdiction-based resource directory and improved "social marketing" of services which are available. Participants report that there is a lack of prevention resources and information on how to use these resources. Providers find that there is limited time and space to provide prevention services and note that increasing the length of an already long appointment can be taxing on the patient.

Transportation

In the 2006-2008 SCSN, transportation was identified as the third greatest need for PLWHA, and the overall greatest problem that clients face while trying to access care. The client-led priority setting process also reflected the significance of this need, as clients in each region voted transportation as one of the top five priorities. Transportation continues to be a major problem, particularly in the rural Maryland regions where there are longer distances to services and extremely limited public transportation. Transportation was cited by participants in all five of the RAC regions. The loss of time seeking out services is a significant barrier for many clients, which contributes to lack of compliance. The need for more mobile vans was stated by participants in several regions.

70.7% of the participants of the 2007 Baltimore EMA Consumer Survey reported the need for medical transportation. Among those with unmet demand, not knowing how to access medical transportation services was cited as a barrier by about half. The survey also asked what forms of transportation respondents had used through this service in the past year. Public transportation was the most common form, utilized by **79.0%** of EMA-wide respondents. Another **35.5 %** had used cabs, and **17.6%** had ridden in medical vans. Volunteer drivers and HIV transportation services were least utilized (**5.5%** and **7.2%** respectively).

VIII. Conclusion

The process used to develop the 2009 SCSN brought together a group of diverse individuals involved in HIV/AIDS services across the state. For many people living with HIV/AIDS, it was an opportunity to voice needs and concerns in order to influence the HIV care system. The process gathered information from a variety of perspectives and several funding streams and identified overarching themes related to emerging trends, critical gaps in services and special populations. In addition to representing different consumer and provider constituencies, SCSN participants represented all different regions of the state. The 2009 SCSN serves as a guide for the goals and objectives developed for the 2009-2011 Part B HIV Services Comprehensive Plan.

IX. Appendices

APPENDIX A: GLOSSARY OF TERMS AND ABBREVIATIONS

AAMSM	African-American Men Who Have Sex With Men
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
HetSexPR	Heterosexual contact with a partner who has or is at risk for HIV
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons Living with AIDS
HRSA	Health Resources Services Administration
IDU	Injection Drug User
MCO	Managed Care Organization
MSM	Men Who Have Sex With Men
Part A	HRSA funding to eligible metropolitan areas for HIV medical and support services
Part B	HRSA funding to states for HIV medical and support services
Part C	HRSA funding directly to clinical providers of HIV early intervention medical services
Part D	HRSA funding for women, infants, children and youth Infected and affected by HIV/AIDS
Planning Council	A mandated council, appointed by the Mayor, of local providers and community members that decides how Ryan White Part A funds will be allocated and Part A programs implemented
PLWHA	Person living with HIV/AIDS
RAC	Regional HIV services advisory groups consisting of HIV providers and HIV-infected and affected community members
Ryan White Act	The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is the reauthorization of a federal law enacted in 1990 that addresses the unmet

	health needs of persons living with HIV disease by funding primary health care and support services.
SCSN	Statewide Coordinated Statement of Need
STD	Sexually Transmitted Disease
UI	The Unique Identifier is a fourteen-digit number consisting of the last four digits of the Social Security number, the date of birth (mm,dd,yyyy), and codes for race/ethnicity and gender

APPENDIX B: RESOURCE INVENTORY 2009

1. 2007 PRC COMMUNITY HEALTH ASSESSMENT FREDERICK COUNTY, MARYLAND

Department: Frederick County Health Department
Purpose: To determine the health status, behaviors and needs of the residents of Frederick Co.
Cycle: Completed in 2007
Respondents: 1000
Method: Telephone interview
Findings:

- Frederick County women are more likely than men to have ever been tested for HIV.
- A greater proportion of young adults (aged 18 to 39) report that they have ever been tested for HIV, compared to adults aged 40 to 64.
- Persons at lower income levels more often report having ever been tested for HIV.
- Black respondents in Frederick County more often report ever being tested for HIV, compared to White or "Other" race respondents.

2. ANALYSIS OF THE MARYLAND AMERICAN INDIAN HEALTH AND HIV/AIDS NEEDS ASSESSMENT

Department: MD AIDS Administration Center for Health Program Development and Management
Purpose: to determine the knowledge, attitudes and practices of Maryland American Indians concerning the issues of HIV/AIDS education, screening/testing and treatment
Cycle: Completed 2004
Respondents: 253
Method: Survey
Findings:

- Those surveyed were well-informed about HIV/AIDS issues, knowledgeable about its transmission and are not involved in high-risk behaviors
- Some misunderstand modes of transmission and which body fluids carry the virus
- Some lack knowledge about appropriate condom use
- Some do not know where to get HIV/AIDS related services

3. BEHAVIORAL SURVEILLANCE STUDY

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: To reduce high-risk behaviors related to the transmission of HIV among HIV-positive individuals.
Cycle: 1st Phase completed in 2005, In 2nd Phase
Method: Interviews and Testing

4. RYAN WHITE CLIENT SATISFACTION SURVEY

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: To understand HIV and AIDS client's experiences with the services of agencies
Cycle: Annual
Method: Survey

5. COMPREHENSIVE PLAN FOR HIV SERVICE DELIVERY IN THE BALTIMORE EMA: 2006 – 2008.

Department: InterGroup Services, Inc.
Purpose: To guides the actions of Ryan White Title I Baltimore-area partners as they strive to maximize the effectiveness of Ryan White funds at ensuring that people living with HIV/AIDS enter, and stay in, medical care.
Cycle: Completed 2005
Method: Community members partnered with public health experts to collect, consider, and apply input directly from persons with, and at risk for, HIV infection.
Findings: Prevention Priorities: 1. HIV – positive persons, 2. Heterosexuals (88 percent African-American), 3.Injection drug users (IDU) (85 percent African-American), 4. Men who have sex with men (MSM) (69 percent African-American), 5. Special populations (DHMH 2005f).

6. BALTIMORE EMA APPLICATION FOR FEDERAL FUNDS, PART A, FY09

7. COMPREHENSIVE PLAN 2006-2008; METROPOLITAN WASHINGTON REGIONAL HEALTH SERVICES PLANNING COUNCIL

8. CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE PROVIDER SURVEY SUMMARY

Department: Wicomico County
Purpose: Assess current resources for those with co-occurring disorders; Identify service gaps, unmet needs and barriers to appropriate service for those with co-occurring disorders; Consider suggestions for improvement of services to those with co-occurring disorders
Cycle: Completed in 2005
Respondents: 19 Providers
Method: Survey
Findings:

- Programs providing addictions services are almost twice as likely to provide co-occurring services to their clients as programs providing mental health services.
- The provision of addictions services was more equally split between private and public providers than was the provision of mental health services where 89% of the providers were private.
- Medical Assistance reimbursements accounted for less than 30% of funding for addictions programs. The majority of mental health agencies report that more than 50% of their funding comes from Medical Assistance reimbursement.
- Chief barriers to the expansion of co-occurring services are professional qualifications and availability of quality services.

9. DOES THE PRESENCE OF A CURRENT PSYCHIATRIC DISORDER IN AIDS PATIENTS AFFECT THE INITIATION OF ANTIRETROVIRAL TREATMENT AND DURATION OF THERAPY?

Department: JHU-Seth Himelhoch, MD, MPH, et al.
Purpose: Investigate whether a current psychiatric disorder; 1) affected the time to initiation of HAART, 2) predicted the likelihood of being prescribed HAART for at least six months, and 3) affected survival in urban AIDS patients
Cycle: Completed 2004
Method: Retrospective Cohort Study
Findings: Patients with a psychiatric disorder were 37% more likely to receive HAART, had more than twice the odds of being prescribed HAART for at least six months, and were 40% more likely to survive as compared to those without a psychiatric disorder.

10. ENGAGING PLWH/As IN CARE: LESSONS LEARNED FOR THE BALTIMORE EMA.

Prepared by InterGroup Services for the Greater Baltimore HIV Health Services Planning Council, August, 2007.

11. ENHANCED PERINATAL SURVEILLANCE

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: Identify areas of missed opportunities in the cascade of services that should be provided to HIV positive pregnant women to eliminate prenatal HIV transmission
Cycle: On-going 2005-2008
Method: Birth registry match; Chart reviews

12. HIV/AIDS EPIDEMIOLOGICAL DATA

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Cycle: Quarterly
Method: Surveillance

13. PERINATAL HIV TESTING FOLLOW-UP SURVEY

Department: Maryland AIDS Administration and MedChi, the Maryland State Medical Society
Purpose: Assessment of perinatal HIV screen policies, practices, and perinatal HIV prevention needs of Maryland hospitals
Cycle: Completed July 2008
Method: Survey
Respondents: 28 labor and delivery hospitals
Findings: About half of those hospitals which responded do not have a policy/protocol for providing rapid HIV tests to women in L & D and half do.

14. HIV/AIDS, SUBSTANCE ABUSE, AND HEPATITIS PREVENTION NEEDS OF NATIVE AMERICANS LIVING IN BALTIMORE: IN THEIR OWN WORDS

Department: Substance Abuse and Mental Health Services Administration

Purpose: Determine the HIV/AIDS, substance abuse, and hepatitis prevention needs of Native Americans living in Baltimore
Cycle: Completed in 2006
Method: Focus groups and Survey

15. MADAP CLIENT SURVEY

Department: MD AIDS Administration Center for HIV Care Services and Center for Surveillance and Epidemiology
Purpose: Assess client satisfaction with MADAP
Cycle: Two years, Completed in December 2008
Method: Survey

16. 2006 MARYLAND STATEWIDE COORDINATED STATEMENT OF NEED SURVEY

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: Conduct a statewide assessment of needs and barriers and evaluate availability of services
Cycle: Completed in 2005
Respondents: 56
Method: Survey
Findings:

- Type of care most difficult to access: Housing
- Greatest needs: Housing, Primary Care, Transportation, Case Management and Client Advocacy, Dental Care
- Barriers to care: Transportation, Concerns about Privacy, Mental Health Co-Morbidity

17. MEDICAL MONITORING PROJECT

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: to provide nationally representative estimates of clinical outcomes (quality of care, access to and use of HIV care, and treatment) and behavioral outcomes (use of prevention services, medication adherence, and levels of ongoing risk behaviors) among persons living with HIV.
Cycle: Annual
Respondents: 149
Method: Interview and Chart abstraction

18. MEDICARE PART D: BALTIMORE EMA IMPACT ASSESSMENT

Department: InterGroup Services
Purpose: To investigate how the changes brought about by Part D might cause dually eligible (for both Medicare and Medicaid) PLWH/As to become clients of services funded under Title I of the CARE Act, thus constituting an additional strain on Title I funds
Cycle: Completed 2006

19. PART B MINORITY AIDS INITIATIVE REPORT

Department: MD AIDS Administration Center for Surveillance and Epidemiology
Purpose: Increase minority enrollment into Maryland's pharmacy assistance programs
Cycle: Annual
Method: Client Outreach Tracking forms and program enrollment data

20. PART A 2007 CONSUMER SURVEY

Department: InterGroup Services, Inc.
Purpose: determine what health care and other needs consumers felt they needed, which needs were not being met and what barriers encountered by consumers when trying to access services
Cycle: Three years
Respondents: 745
Method: Interview Administered Survey
Findings: percentage of Clients' needs NOT met: Legal (69.3 %), Hospice (69.2%), Home Health (64.2%), Day/Respite (60.0%), Child Care < 6 yrs. (59.5%), Rehabilitation (59.0%)

21. PERINATAL RAPID HIV TESTING: A SURVEY OF HOSPITAL LABOR AND DELIVERY UNITS IN MD

22. REGIONAL ADVISORY COMMITTEE (RAC) MEETING MINUTES

Department: MD AIDS Administration Center for HIV Care Services and Center for Prevention
Cycle: Quarterly

23. WASHINGTON DC EMA APPLICATION FOR RYAN WHITE FUNDS, OCTOBER, 2008

APPENDIX C:

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE

Second Quarter 2008 - Data reported through June 30, 2008

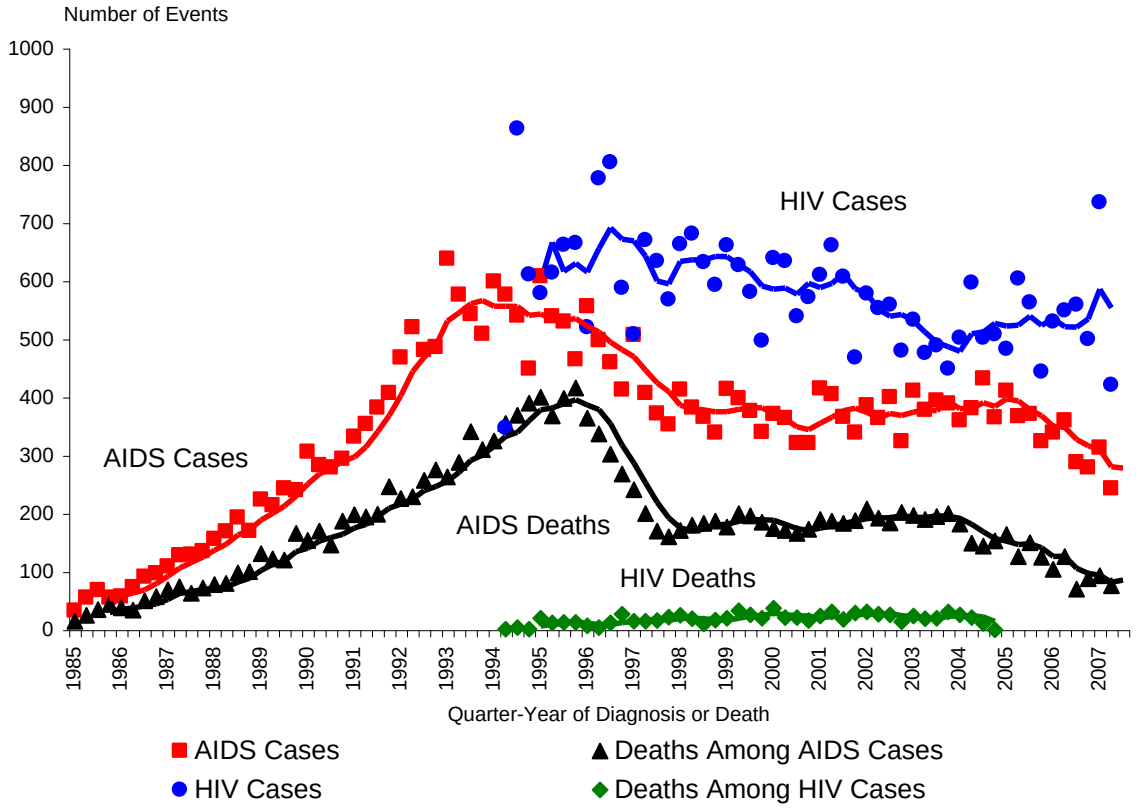
AIDS Administration
Maryland Department of Health and Mental Hygiene
www.dhmh.state.md.us/AIDS/
1-800-358-9001

SPECIAL NOTE ON HIV REPORTING

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV/AIDS reporting and required that HIV cases be reported by name. The reporting period presented in this report includes the first first full year of the new reporting, however, most of the tables and figures are as of the end of code-reporting and are unaffected by this change. Section X has been modified to include the changes and future reports will have additional modifications. For additional information on HIV reporting please visit the AIDS Administration web site at the above address.

Section I - HIV and AIDS Case Trends

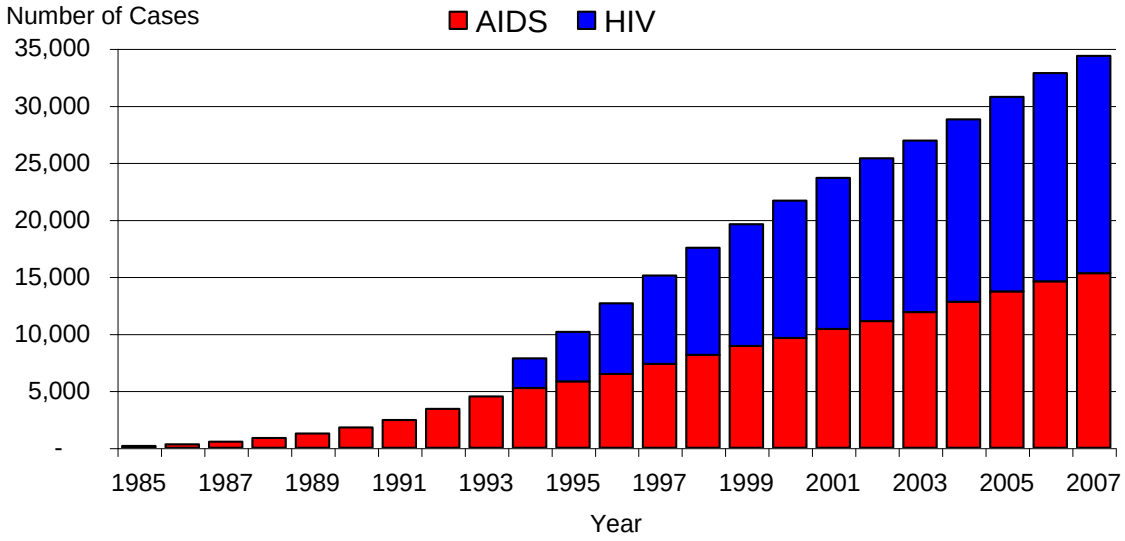
Incident (Newly Diagnosed) HIV and AIDS Cases and Deaths among HIV and AIDS Cases by Quarter-Year through Second Quarter 2007 as Reported through 6/30/08



HIV case reporting began in June of 1994.
Trend lines are weighted moving averages (over 4 quarters).

Section II - HIV and AIDS Case Prevalence Trends

Prevalent (Living) HIV and AIDS Cases on December 31st of Each Year as Reported through 6/30/08



YEAR	HIV	AIDS	Total HIV/AIDS
1985		160	160
1986		301	301
1987		526	526
1988		866	866
1989		1,254	1,254
1990		1,776	1,776
1991		2,431	2,431
1992		3,418	3,418
1993		4,496	4,496
1994	2,594	5,237	7,831
1995	4,348	5,814	10,162
1996	6,194	6,480	12,674
1997	7,735	7,364	15,099
1998	9,380	8,150	17,530
1999	10,676	8,924	19,600
2000	12,039	9,626	21,665
2001	13,238	10,413	23,651
2002	14,262	11,103	25,365
2003	15,026	11,895	26,921
2004	15,974	12,807	28,781
2005	17,049	13,716	30,765
2006	18,246	14,594	32,840
2007	19,042	15,297	34,339

Prevalent cases were alive on December 31st of the given year.
June 30th for HIV in 2007
HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section III - HIV and AIDS Case Geography

Incidence (Newly Diagnosed Cases) during 7/1/06-6/30/07 and Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
JURISDICTION	No.	%	No.	%	No.	%	No.	%	No.	%
Allegany	4	0.2%	4	0.4%	34	0.2%	35	0.2%	69	0.2%
Anne Arundel	71	3.2%	39	3.5%	501	2.6%	501	3.3%	1002	2.9%
Baltimore City	979	44.2%	475	42.3%	9447	49.6%	6989	46.6%	16436	48.3%
Baltimore	218	9.8%	101	9.0%	1407	7.4%	1114	7.4%	2521	7.4%
Calvert	5	0.2%	7	0.6%	42	0.2%	53	0.4%	95	0.3%
Caroline	5	0.2%	3	0.3%	32	0.2%	24	0.2%	56	0.2%
Carroll	12	0.3%	2	0.2%	98	0.5%	56	0.4%	154	0.5%
Cecil	1	0.4%	4	0.4%	38	0.2%	60	0.4%	98	0.3%
Charles	18	0.4%	20	1.8%	133	0.7%	125	0.8%	258	0.8%
Dorchester	5	0.2%	3	0.3%	60	0.3%	60	0.4%	120	0.4%
Frederick	13	0.6%	4	0.4%	159	0.8%	110	0.7%	269	0.8%
Garrett	0	0.0%	0	0.0%	5	0.0%	4	0.0%	9	0.0%
Harford	50	2.3%	22	1.2%	217	1.1%	191	1.3%	408	1.2%
Howard	31	1.4%	13	1.2%	191	1.0%	172	1.1%	363	1.1%
Kent	0	0.0%	1	0.1%	19	0.1%	17	0.1%	36	0.1%
Montgomery	260	11.7%	135	12.0%	1521	8.0%	1466	9.8%	2987	8.8%
Prince George's	399	18.0%	257	22.9%	2760	14.5%	2732	18.2%	5492	16.1%
Queen Anne's	0	0.0%	0	0.0%	14	0.1%	23	0.2%	37	0.1%
Saint Mary's	1	0.0%	5	0.4%	35	0.2%	48	0.3%	83	0.2%
Somerset	9	0.4%	2	0.2%	54	0.3%	27	0.2%	81	0.2%
Talbot	3	0.1%	1	0.1%	29	0.2%	27	0.2%	56	0.2%
Washington	41	1.9%	8	0.7%	224	1.2%	112	0.7%	336	0.8%
Wicomico	29	1.3%	4	0.4%	203	1.1%	92	0.6%	295	0.9%
Worcester	9	0.4%	4	0.4%	50	0.3%	39	0.3%	89	0.3%
Corrections	52	2.3%	10	0.9%	1769	9.3%	905	6.0%	2674	7.9%
STATE TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%
*STATE RATE**	*41.8*		*21.2*		*359.5*		*282.9*		*642.4*	

HIV case reporting began in 1994.
For code-based HIV cases reported 7/1/06 through 6/30/07, the median time from diagnosis to report was less than one month. For AIDS cases reported 7/1/07 through 6/30/08, the median time from diagnosis to report was three months.
*Rate is number of cases per 100,000 population. Population was based on 2000 Census.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section IV - HIV and AIDS Case Demographics

Incidence (Newly Diagnosed Cases) during 7/1/06-6/30/07 and Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
GENDER	No.	%	No.	%	No.	%	No.	%	No.	%
Male	1379	62.3%	692	61.6%	11873	62.5%	9937	66.3%	21810	64.2%
Female	833	37.7%	432	38.4%	7109	37.5%	5045	33.7%	12154	35.8%
Missing*	3				60				60	
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
RACE/ETHNICITY	No.	%	No.	%	No.	%	No.	%	No.	%
White	273	17.0%	139	12.4%	2173	14.0%	2354	15.7%	4527	14.9%
African-American	1205	75.2%	923	82.1%	12604	81.4%	12086	80.7%	24690	81.1%
Hispanic	42	2.6%	51	4.5%	278	1.8%	464	3.1%	742	2.4%
Other	82	5.1%	11	1.0%	424	2.7%	78	0.5%	502	1.6%
Missing*	613				3563				3563	
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
AGE**	No.	%	No.	%	No.	%	No.	%	No.	%
<5 (Pediatric)	11	0.5%	0	0.0%	37	0.2%	3	0.0%	40	0.1%
5-12 (Pediatric)	5	0.2%	0	0.0%	112	0.6%	29	0.2%	141	0.6%
13-19	66	3.0%	23	2.0%	159	0.8%	132	0.9%	291	0.9%
20-29	464	20.9%	140	12.5%	1815	9.5%	692	4.6%	2507	7.4%
30-39	519	23.4%	296	30.3%	4126	21.7%	2667	23.0%	6793	20.0%
40-49	702	31.7%	411	36.6%	7325	38.5%	6348	42.4%	13673	40.2%
50-59	360	16.3%	200	17.8%	4273	22.4%	4019	26.8%	8292	24.4%
60+	88	4.0%	54	4.8%	1195	6.3%	1092	7.3%	2287	6.7%
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

HIV case reporting began in 1994.
*Cases with missing race or gender were excluded from percent distributions.
**For incident cases, age was at time of diagnosis. For prevalent cases, age was as of 6/30/07.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section V - HIV/AIDS Case Expanded Demographics

Total HIV/AIDS Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

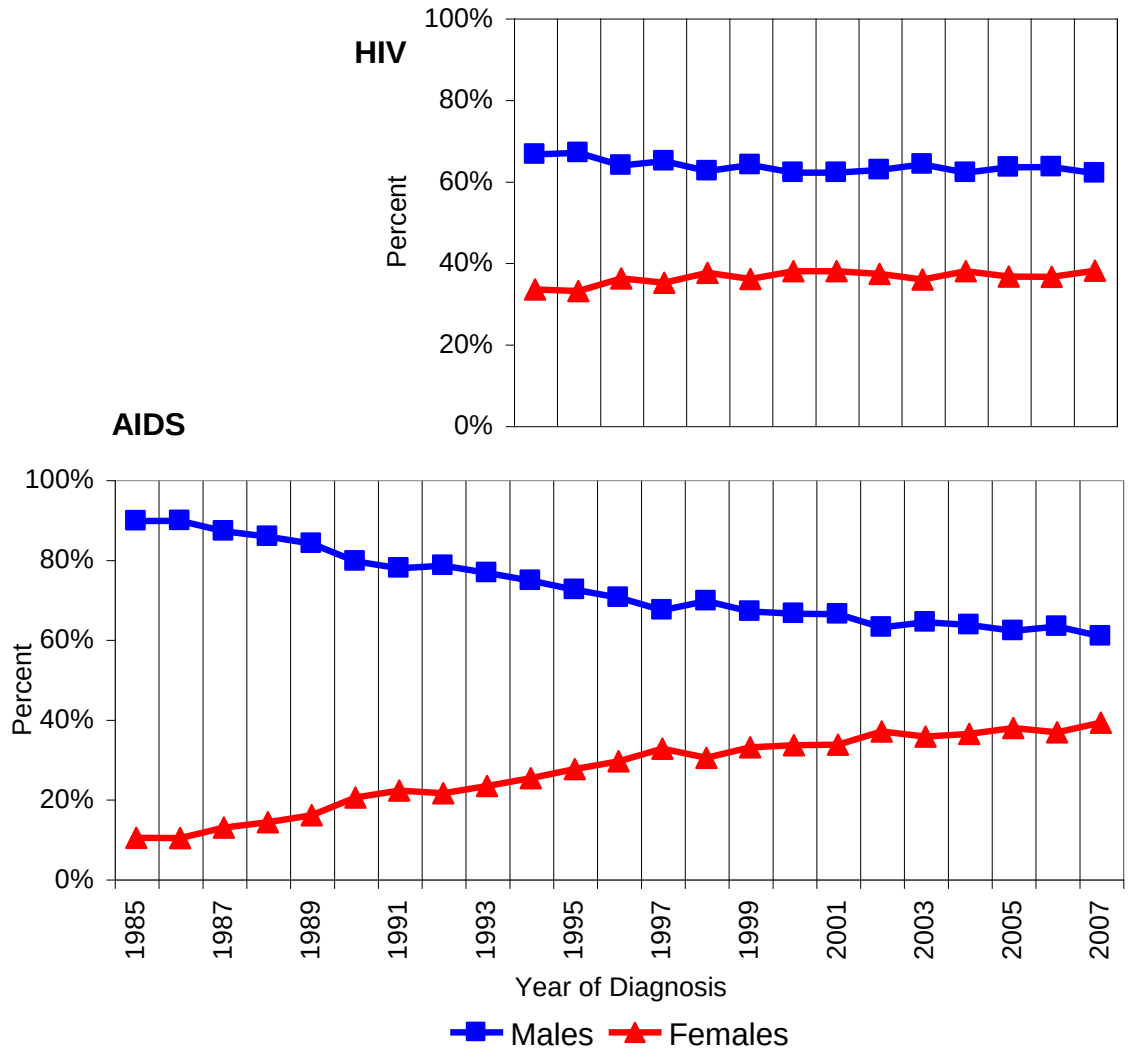
	RACE/ETHNICITY					
GENDER/AGE	White	African-American	Other	Missing Race/ Ethnicity	Total	
	No.	No.	No.	No.	No.	%
Male						
<5 (Pediatric)	1	10	0	12	23	0.1%
5-12 (Pediatric)	10	60	4	16	90	0.4%
13-19	4	112	4	17	137	0.6%
20-29	157	1062	67	178	1464	6.7%
30-39	563	2318	239	407	3527	21.6%
40-49	1438	6494	297	723	8952	41.0%
50-59	841	4472	170	455	5938	27.2%
60+	282	1146	45	206	1679	7.7%
SUBTOTAL	3296	15674	826	2014	21810	100.0%
Female						
<5 (Pediatric)	3	5	0	8	16	0.1%
5-12 (Pediatric)	1	41	1	8	51	0.4%
13-19	12	121	0	21	154	1.4%
20-29	126	664	57	192	1039	8.5%
30-39	386	2210	169	494	3259	26.8%
40-49	458	3656	118	461	4693	38.6%
50-59	181	1863	60	236	2340	19.3%
60+	56	445	11	90	602	5.0%
SUBTOTAL	1223	9005	416	1510	12154	100.0%
Missing Gender	8	11	2	39	60	
TOTAL	4527	24690	1244	3563	34024	

HIV case reporting began in 1994.
Age was as of 6/30/07.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VI - HIV and AIDS Case Gender Trends

Proportions by Gender of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08

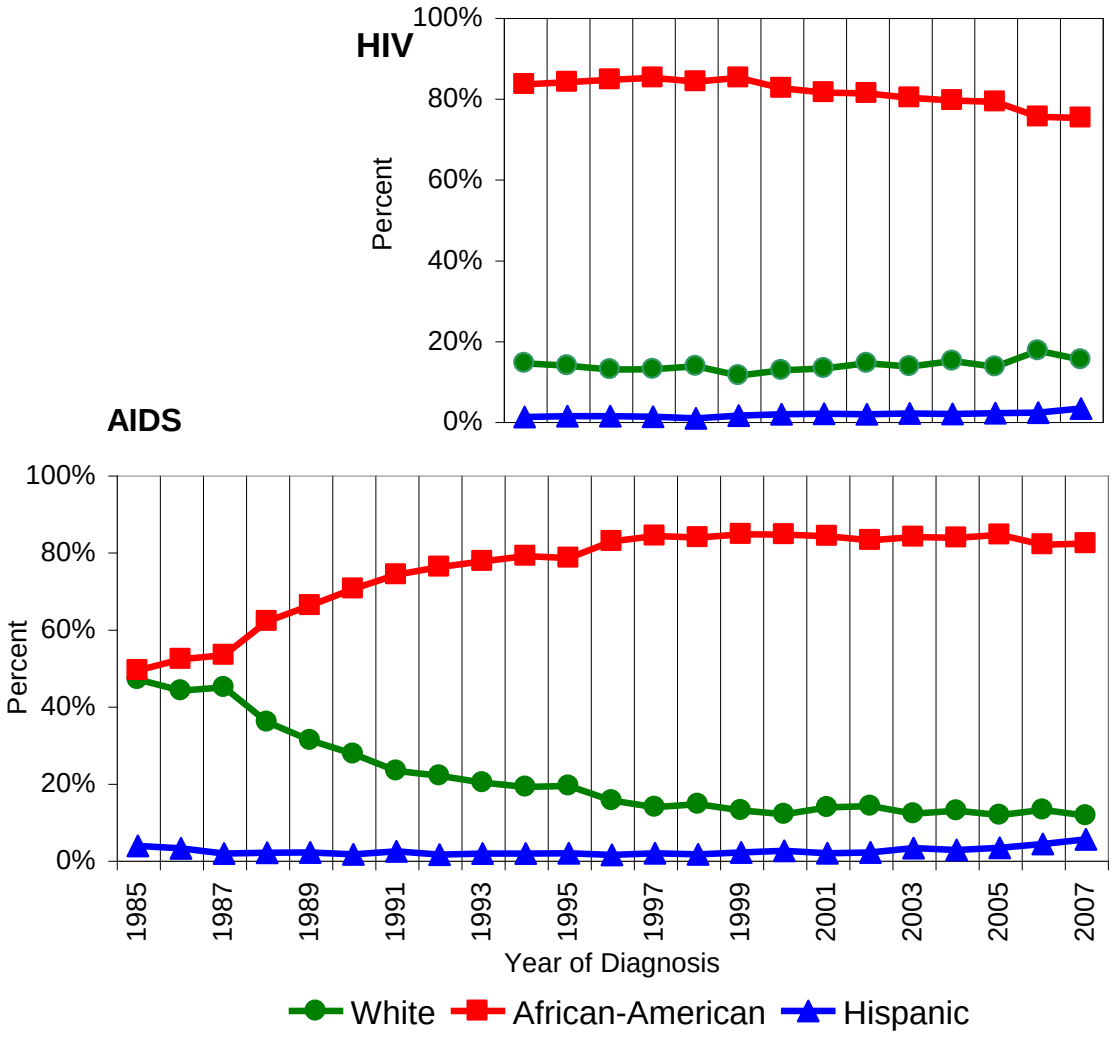


HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VII - HIV and AIDS Case Race/Ethnicity Trends

Proportions by Race/Ethnicity of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08

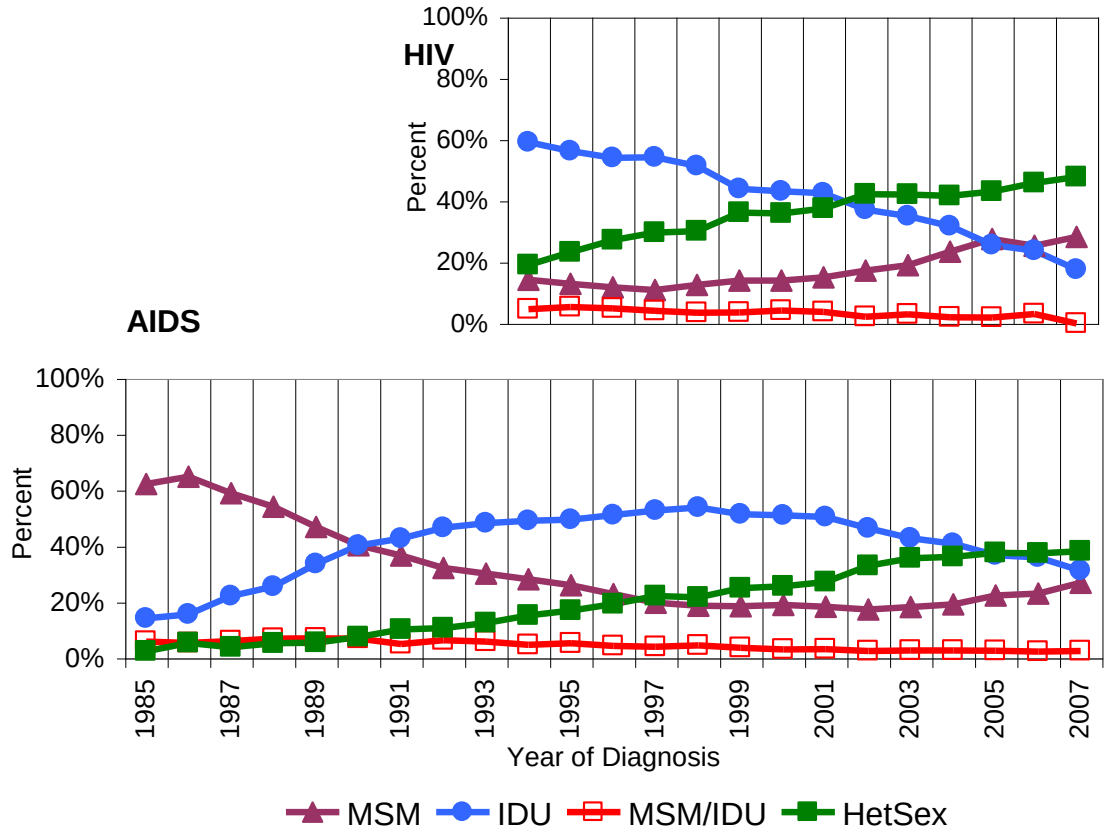


HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VIII - HIV and AIDS Case Exposure Category Trends

Proportions by Exposure Category of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08



Other exposure categories (not shown) that account for small percentages of cases include hemophiliacs, transfusion recipients, pediatric transmissions and occupational exposures.
Percent distributions exclude cases with exposure category under investigation and risk not specified.
Maryland data had exposure on 54% of HIV cases and 92% of AIDS cases.
HIV case reporting began in 1994.

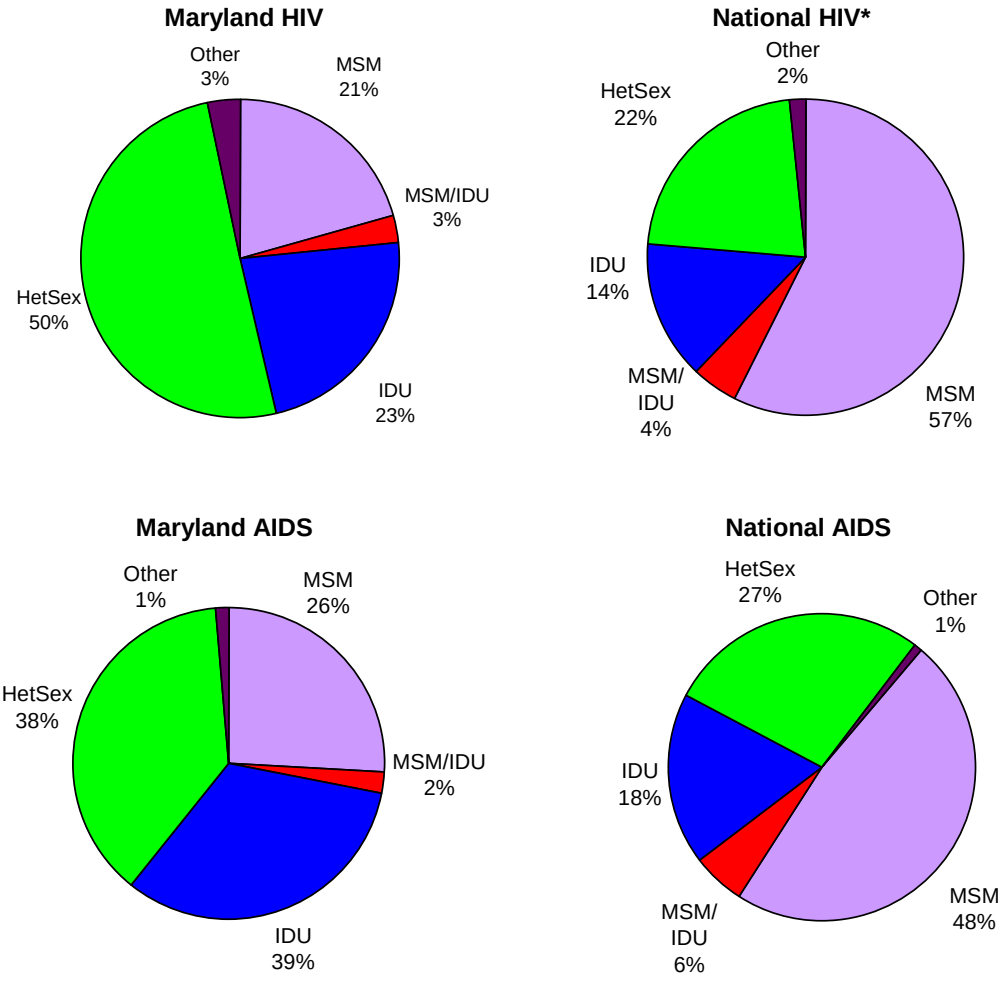
MSM = Men who had sex with men
IDU = Injection drug users
MSM/IDU = Men who had sex with men and were injection drug users
HetSex = Heterosexual contact

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section IX - Comparisons to National Statistics

HIV and AIDS Cases Reported during 1/1/06-12/31/06

Maryland had the third highest annual AIDS case report rate of any state in 2006 (29.0 cases per 100,000 population) and Baltimore-Towson had the second highest rate of any metropolitan area in 2006 (37.7 cases per 100,000 population). The national rate in 2006 was 12.9 cases per 100,000 population.



* National HIV data included only persons with HIV infection that had not progressed to AIDS. National data was only available from the 45 states and 5 territories with confidential name-based HIV infection reporting as of 12/31/06. Maryland HIV and AIDS data were reported as mutually exclusive categories for comparison to national statistics.

Percent distributions excluded cases with occupational exposure, exposure category under investigation, and risk not specified.

Source for national data: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2006;18:29-38.

MSM = Men who had sex with men
IDU = Injection drug users
MSM/IDU = Men who had sex with men and were injection drug users
HetSex = Heterosexual contact
Other = Hemophiliacs, transfusion recipients, and pediatric transmissions

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section X - HIV and AIDS Case Reports by Jurisdiction

Events Reported during the Last Year (7/1/07-6/30/08) and Cumulatively through 6/30/08

	HIV Cases					AIDS Cases			AIDS Deaths		
	by Code		by Name								
	Non-AIDS Cumulative		Year	Non-AIDS Cumulative		Year	Cumulative		Year	Cumulative	
JURISDICTION	No.	%	No.	No.	%	No.	No.	%	No.	No.	%
Allegany	39	0.2%	19	29	0.3%	12	71	0.2%	1	33	0.2%
Anne Arundel	505	2.6%	172	278	3.0%	55	1034	3.2%	9	509	3.0%
Baltimore City	9746	49.9%	3000	5380	57.1%	530	16641	51.7%	153	9489	56.7%
Baltimore	1433	7.3%	360	644	6.8%	120	2261	7.0%	15	1106	6.6%
Calvert	45	0.2%	28	30	0.3%	11	98	0.3%	1	44	0.3%
Caroline	32	0.2%	21	31	0.3%	6	60	0.2%	0	34	0.2%
Carroll	99	0.5%	46	59	0.6%	7	105	0.3%	1	47	0.3%
Cecil	39	0.2%	33	37	0.4%	4	112	0.3%	0	52	0.3%
Charles	135	0.7%	74	81	0.9%	17	225	0.7%	3	94	0.6%
Dorchester	64	0.3%	12	35	0.4%	7	129	0.4%	2	66	0.4%
Frederick	164	0.8%	19	29	0.3%	8	207	0.6%	1	93	0.6%
Garrett	5	0.0%	1	1	0.0%	1	8	0.0%	0	4	0.0%
Harford	219	1.1%	54	95	1.0%	24	384	1.2%	1	183	1.1%
Howard	194	1.0%	59	89	0.9%	16	346	1.1%	2	165	1.0%
Kent	17	0.1%	13	16	0.2%	3	34	0.1%	0	14	0.1%
Montgomery	1536	7.9%	281	388	4.1%	146	2721	8.4%	9	1188	7.1%
Prince George's	2790	14.3%	750	1348	14.3%	270	5309	16.5%	17	2424	14.5%
Queen Anne's	16	0.1%	4	10	0.1%	2	55	0.2%	0	30	0.2%
Saint Mary's	36	0.2%	25	32	0.3%	12	92	0.3%	1	39	0.2%
Somerset	55	0.3%	13	18	0.2%	1	60	0.2%	0	33	0.2%
Talbot	29	0.1%	14	32	0.3%	2	83	0.3%	1	55	0.3%
Washington	235	1.2%	97	114	1.2%	20	209	0.6%	0	90	0.5%
Wicomico	209	1.1%	46	58	0.6%	5	249	0.8%	1	155	0.9%
Worcester	52	0.3%	11	16	0.2%	1	94	0.3%	0	54	0.3%
Corrections	1844	9.4%	325	565	6.0%	22	1627	5.1%	11	726	4.3%
TOTAL	19538	100.0%	5477	9415	100.0%	1302	32214	100.0%	229	16727	100.0%

Laboratory reporting of HIV cases by code existed from June 1, 1994 to April 24, 2007.
Provider and laboratory reporting of HIV cases by name has existed since April 24, 2007.

Maryland is re-reporting code HIV cases by name, therefore, the same person may appear as a code HIV case and as a name HIV case.

Year data were for events reported during the prior year, including events that occurred earlier.
HIV cases reported during the prior year may also have been reported as AIDS cases during that time.
Non-AIDS cumulative HIV cases included all HIV cases reported through the end of the period, that had not been reported as AIDS cases by the end of the period.
AIDS deaths included all causes of death.

The median time from diagnosis to report was one month for cumulative non-AIDS HIV code cases, 21 months for cumulative non-AIDS HIV name cases, and four months for cumulative AIDS cases.

APPENDIX D: REGIONAL EPIDEMIOLOGICAL NARRATIVES

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV and AIDS reporting, instituted reporting for HIV-exposed newborns, changed Maryland's HIV reporting from a code-based to a name-based system as is done with AIDS cases, increased the restrictions on the use of surveillance data, and increased the penalties for misuse of surveillance data. The state is in the midst of a major effort to transition from code-based to name-based HIV surveillance; hence, the data collected under the new system were not yet available for this report.

This report uses the HIV and AIDS surveillance data available in 2008 that was used during the statewide planning process and for the FY2009 Ryan White funding application. Under this system, AIDS cases and symptomatic HIV cases were reported to the health department using the patient's name by physicians. HIV positive test results and CD4+ T-lymphocyte cell counts less than 200 cells per microliter were reported to the health department using a patient unique identifier number by all laboratories licensed by the State of Maryland. HIV data are available only for those tested since 1994, when HIV surveillance began. HIV and AIDS incident cases are not necessarily mutually exclusive since HIV cases may have progressed to AIDS during the presented time period and therefore count as both a new case of HIV and a new case of AIDS. HIV and AIDS prevalent cases are mutually exclusive categories; therefore, HIV prevalent cases are only those cases that have not developed AIDS. Due to the delay in case reporting, the data are presented with a one year lag, at which point it is estimated that over 90% of cases will have been reported.

Central Region

The number of incident (new) AIDS cases diagnosed within each quarterly period in the Maryland Ryan White Part B Central Region (Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties) increased through 1995 to a high of around 325 cases per quarter, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995, to a high of 276 in the first quarter of 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a substantial decline in both the number of new cases of AIDS (to 195 in the third quarter of 2000) and in deaths among AIDS cases (to 138 in the first quarter of 2004). The number of deaths among AIDS cases declined initially at a faster rate than the number of new AIDS cases per year, resulting in an increase in the number of people living with AIDS each year (prevalence). However, the decrease in AIDS deaths stopped in 1998 and the number of deaths per quarter has been stable through 2004 and then began declining again. The number of new HIV cases reported each quarter has been decreasing since surveillance began in 1994 (to 315 in the fourth quarter of 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were a total of 20,199 living HIV and AIDS cases in the Maryland Ryan White Part B Central Region as of December 31, 2006, of which 11,448 (57%) were HIV cases and 8,751 (43%) were AIDS cases. Sixty-two percent of all living HIV and AIDS cases in Maryland were residents of the Central Region at time of diagnosis. Of the cases in the Central Region, 78% were residents of Baltimore City and 12% of Baltimore County.

Central Region living HIV and AIDS cases are predominantly African-American (84%), male (63%), and middle-aged; 61% of cases are 30-49 years old. The percentage of female cases has remained steady over time at 37% of new HIV cases. The percentage of African-American cases has declined slightly over time to 79% of new HIV cases. The percentage of cases aged 40-49 at time of diagnosis has also risen to 36% of new HIV cases in 2006.

Forty-five percent of all living HIV and AIDS cases with known transmission risk report injection drug use (IDU), 31% report heterosexual contact (HetSex), and 18% report men who have sex with men (MSM) as mode of exposure. Injection drug use is the predominant mode of exposure reported among men in the Central Region, but IDU and HetSex are equally common among women.

Injection drug use was the most common mode of exposure among new HIV cases, but has been declining steadily, and since 2005, heterosexual contact has been the most common (47% HetSex, 27% IDU in 2006). The proportion of cases among men who have sex with men has also been rising, to 20% in 2006.

Eastern Region

The number of incident (new) AIDS cases diagnosed within each year increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a substantial decline in both the number of new AIDS cases (to 28 in 2002) and in deaths among AIDS cases (to 17 in 1999). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). Since the number of new HIV cases reported each year is greater than the number of deaths, the total number of living HIV cases (reported since 1994) and living AIDS cases has been steadily increasing.

There were a total of 833 living HIV and AIDS cases in the Maryland Ryan White Part B Eastern Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties) as of December 31, 2006. Of these 833 living cases in the Eastern region, 476 (57%) were HIV cases and 356 (43%) were AIDS cases. Of all reported HIV/AIDS cases in Maryland, 3% were residents of the Eastern Region at time of diagnosis. Of the cases reported in the Eastern Region, 33% were residents of Wicomico County and 14% were residents of Dorchester County.

Eastern Region HIV/AIDS cases are predominantly African American (64%), male (64%), and middle-aged - 61% of cases are 30-49 years old. The percentage of female HIV cases has increased slightly over time. The percentage of African-American cases in the Eastern region has increased, and became the largest racial/ethnic group in 1995. The percentage of HIV cases age 40-49 at diagnosis has been increasing and surpassed age group 30-39 to become the largest percent of new HIV cases in 2004.

Heterosexual contact (HetSex) has represented increasing proportions of all new HIV cases in the Eastern Region and is currently the most common mode of HIV transmission. Thirty-one percent of all living HIV/AIDS cases are MSMs, 21% are IDUs, and 44% report heterosexual contact (HetSex).

Southern Region

The number of incident (new) AIDS cases diagnosed within each year increased through 1996. There was an artificial rise in 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a decline in both the number of new cases of AIDS (to 13 in 2001) and in deaths among AIDS cases (to 5 in 2004). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). The number of new HIV cases each year in the Southern Region has been decreasing by 2% per year (to 26 cases in 2006). Overall, the total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing.

There were a total of 414 living HIV and AIDS cases in the Southern Region (Calvert, Charles, and Saint Mary's counties) as of December 31, 2006, of which 204 (49%) were HIV cases and 211 (51%) were AIDS cases. One percent of all living HIV and AIDS cases in Maryland were residents of the Southern Region at time of diagnosis. Of the cases in the Southern Region, 61% were residents of Charles County, 20% of Calvert County and 19% of St. Mary's County.

Southern Region HIV and AIDS living cases are predominantly African American (68%), male (60%), and 30-49 years old (68%). The percentage of newly diagnosed female HIV cases has increased slightly over time. The percentage of African-American HIV cases has generally increased over time, and African Americans have been the predominant racial/ethnic group newly diagnosed with HIV since 1994. Among new HIV cases, the proportion aged 30-39 has been decreasing slightly, while the proportion 20-29 has been increasing slightly.

Heterosexual contact (HetSex) has represented increasing proportions of all new HIV cases and is currently the most common mode of HIV transmission in the Southern Region. The proportion of new HIV cases that are MSM has also been increasing. Fifty percent of all living HIV/AIDS cases in the Southern Region report HetSex as the mode of transmission, 31% are men who have sex with men (MSM), and 15% are injection drug users (IDU).

Suburban Region

The number of incident (new) AIDS cases diagnosed within each quarterly period in the Maryland Ryan White Part B Suburban Region (Montgomery and Prince George's counties) increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a substantial decline in both the number of new cases of AIDS (to 67 in the fourth quarter of 1997) and in deaths among AIDS cases (to 29 in the second quarter of 2002). The number of new AIDS cases has been increasing since 1998, while the number of deaths among AIDS cases has continued to decline, resulting in a continued increase in the number of people living with AIDS each year

(prevalence). The number of new HIV cases reported each year has been generally increasing by 4% per year since surveillance began in 1994 (to 139 in the fourth quarter of 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were a total of 8,023 living HIV and AIDS cases in the Maryland Ryan White Part B Suburban Region as of December 31, 2006, of which 4,048 (50%) were HIV cases and 3,976 (50%) were AIDS cases. Twenty-four percent of all living HIV and AIDS cases in Maryland were residents of the Suburban Region at time of diagnosis. Of the cases in the Suburban Region, 65% were residents of Prince George's County and 35% of Montgomery County.

Suburban Region living HIV and AIDS cases are predominantly African-American (79%), male (61%), and middle-aged; 64% of cases are 30-49 years old. The percentage of female cases has increased slightly over time to 39% of new HIV cases in 2006. The percentage of African-American cases has been decreasing, to 72% of new HIV cases in 2006. The proportion of cases with race/ethnicity reported as "other", many of whom are recent African immigrants, has been increasing and was 18% in 2006. The age group 30-39 year old has been decreasing, while the age group 40-49 old has been increasing.

In 1994, the Suburban Region had roughly equal proportions of heterosexual contact (HetSex, 30%), injection drug use (IDU, 35%), and men who have sex with men (MSM, 28%) among the new HIV cases. Since then, the region has experienced a substantial increase in the proportion of new HIV cases that report HetSex as their HIV exposure (57% of new cases in 2006) and an equally dramatic decrease in injection drug use (IDU) cases (5% in 2006). After a long, gradual decline, MSM cases have surged during the last two years to 35% in 2006). Among prevalent cases on 12/31/2006, HetSex represented 49%, MSM 31%, and IDU 15%.

Western Region

The number of incident (new) AIDS cases diagnosed each year in the Maryland Ryan White Part B Western Region (Allegany, Frederick, Garrett, and Washington counties) increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a decline in both the number of new cases of AIDS (to 14 in 1997) and in deaths among AIDS cases (to 2 in 1998). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). Since 1998, there have been no major changes in the number of AIDS cases or deaths in Western Maryland. The number of new HIV cases diagnosed in Western Maryland each year has been increasing since surveillance began in 1994 (to 63 in 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were 656 living HIV and AIDS cases in the Maryland Ryan White Part B Western Region as of December 31, 2006, of which 406 (62%) were HIV cases and 250 (38%) were AIDS cases. Two percent of all living HIV and AIDS cases in Maryland were residents of the Western Region at the time of diagnosis. Of the cases in the Western Region, 40% were residents of Frederick County and 49% of Washington County.

Living HIV and AIDS cases in the Western Region of Maryland are predominantly white (61%), male (72%), and middle-aged (65% of cases are 30-49 years old). The percentage of female cases has been increasing slightly over time. The percentage of African-American cases has been increasing over time. Men who have sex with men (MSM) is the most common mode of transmission reported by living HIV and AIDS cases in Western Maryland (41%). Heterosexual exposure (HetSex) has represented an increasing proportion of all new HIV cases and is now the most common exposure category among new HIV cases (40% in 2006).

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